



State of Maryland
OFFICE OF THE ATTORNEY GENERAL

HEALTH INSURANCE CARRIER
APPEALS AND GRIEVANCES PROCESS

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HEALTH EDUCATION AND ADVOCACY UNIT
CONSUMER PROTECTION DIVISION
OFFICE OF THE ATTORNEY GENERAL

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I. Executive Summary

The Health Education and Advocacy Unit (the “HEAU”) of the Office of the Attorney General’s Consumer Protection Division submits this annual report on the implementation of the Health Insurance Carrier Appeals and Grievances Law¹ (the “Appeals and Grievances Law”) as required by the Maryland Insurance Article §15-10A-08 and the Maryland Commercial Law Article §13-4A-04. Section 15-10A-08(b)(1) of the Maryland Insurance Article requires the HEAU to publish annually a summary report on the grievances and complaints filed with or referred to a carrier, the Commissioner of the Maryland Insurance Administration (the “MIA”), the HEAU, or any other federal or State government agency or unit during the previous fiscal year. Section 15-10A-08(b)(2) of the Maryland Insurance Article also requires the HEAU to evaluate the effectiveness of the internal grievance and complaint processes available to members, and to include in its annual summary report the results of this evaluation and any proposed changes to the law that the HEAU considers necessary.

This report covers grievances and complaints filed or referred during State Fiscal Year 2025, beginning July 1, 2024, and concluding June 30, 2025.

This report (1) summarizes the Appeals and Grievances Law; (2) discusses how health insurance carriers, the MIA, and the HEAU implement the Appeals and Grievances Law; (3) summarizes grievances and complaints handled by carriers, the MIA and the HEAU; and (4) provides additional information about HEAU activities and legislative recommendations to strengthen consumer protections in the health care marketplace.

II. Overview of the Appeals and Grievances Process

State Law

In 1998, the General Assembly enacted the Appeals and Grievances Law to provide patients a process for appealing their health insurance carriers’² medical necessity “adverse decisions.” All carriers must establish a grievance process that complies with the Appeals and Grievances Law. The Appeals and Grievances Law established guidelines that carriers must follow in notifying patients of denials, establishing appeals and grievances processes, and notifying members of grievance decisions.

In 2000, the General Assembly enacted Chapter 371³ that expanded the grievances process to include the right to appeal contractual “coverage decisions.” As a result, patients in Maryland who have coverage from a State-regulated plan can challenge any decision by a carrier that results

¹ Md. Code Ann., Insurance §15-10A-01 through §15-10A-10.

² The Appeals and Grievances Law currently defines “carrier” as a person that offers a health benefit plan and is: (1) an authorized issuer that provides health insurance in the State; (2) a nonprofit health service plan; (3) a health maintenance organization; (4) a dental plan organization; (5) a self-funded student health plan operated by an independent institution of higher education...that provides health care to its students and their dependents; or, (6) except for a managed care organization... any other person that provides health benefit plans subject to regulation by the State. Md. Code Ann., Insurance § 15-10A-01(c).

³ Md. Code Ann., Insurance § 15-10D-01 through §15-10D-04.

in the total or partial denial of a covered health care service. In 2011, the General Assembly enacted Chapters 3 and 4,⁴ which expanded the definition of “coverage decisions” to include a carrier’s decision that someone is ineligible for coverage or a carrier’s decision that results in the rescission of an individual’s coverage.

In 2023, the General Assembly enacted Chapter 229⁵ to implement section 110 of the federal No Surprises Act requiring, among other things, beginning not later than January 1, 2023, that the external review process apply with respect to any adverse determination by a carrier under Public Health Service Act sections 2799A–1 (preventing surprise medical bills for out-of-network emergency services and services by out-of-network providers at in-network facilities) and 2799A–2 (ending surprise air ambulance bills).

As a result, patients with Maryland-regulated plans have been able to challenge any decision by a carrier that results in the total or partial denial of a covered health care service, the denial of eligibility for coverage, the rescission of coverage, or the failure to apply the cost-sharing and surprise billing protections in the No Surprises Act.

Maryland law has two similar processes for patients to dispute carrier determinations: one for carriers’ denials that proposed or delivered health care services are not or were not *medically necessary* (“adverse decisions”), and another for carriers’ determinations that result in the *contractual exclusion* of a health care service (“coverage decisions”).

Federal Law

Under the Patient Protection and Affordable Care Act (the “ACA”) and the No Surprises Act, consumers have the right to appeal health plans’ decisions rendered after March 23, 2010. Guidance and regulations issued by the U.S. Departments of Health and Human Services (“HHS”), Labor, and Treasury⁶ standardized internal claims and appeals and external review processes for group health insurance plans and health insurance issuers offering coverage in the group and individual markets. Under the regulations, consumers have the right to:

1. information about why a claim or coverage has been denied and how they can appeal that decision;
2. appeal to the insurance company to conduct a full and fair review of its decision (*internal appeals*); and
3. appeal to an independent third-party review organization (“IRO”) for review of the carrier’s decision (*external review*) for claims that involve (a) medical judgment (including but not limited to those based on the plan’s requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational), as determined by the external reviewer; (b) a rescission of coverage (whether or not the

⁴ Chapters 3 and 4 made other changes to processes and rights under the Appeals and Grievances Law that became effective July 1, 2011.

⁵ Md. Code Ann., Insurance § 15-146(b)(application of No Surprises Act)-(d)(MIA No Surprises Act enforcement authority).

⁶ 26 CFR Parts 54 and 602 (Treasury); 29 CFR 2590 (Labor); 45 CFR 147 (HHS)(October 7, 2021).

rescission has any effect on any particular benefit at that time); or (c) surprise billing and cost-sharing prohibited under the No Surprises Act.

Accordingly, Maryland continues to implement the Appeals and Grievances Law as described below.

III. Phases of the Appeals and Grievances Process

For both adverse decisions and coverage decisions, the appeals and grievances process begins when a patient receives notice from the carrier that the carrier has rendered an adverse decision or coverage decision. Carriers must provide patients with a written notice that clearly states the basis of the carrier's adverse or coverage decision, and that the HEAU is available to mediate the dispute with the carrier or, if necessary, help the patient file a grievance or appeal. The notice must also inform the patient that an external review of the decision is available through the MIA or other external reviewer following exhaustion of the carrier's internal process. Patients may file a complaint with the MIA or other external reviewer prior to exhausting the internal grievance process only when there is a compelling reason.

After receiving the initial denial, the patient⁷ may contest the determination through the carrier's internal grievance or appeal process. After receiving the grievance or appeal, the carrier has 30 working days to review adverse decisions involving pending care and 45 working days for already-rendered care. For coverage decisions, the carrier has 60 working days after the date the grievance was filed with the carrier to render a decision. The carrier must issue a written decision to the patient at the conclusion of this internal process.

If the carrier's final decision is unfavorable, the patient may file a complaint with the MIA or other external reviewer for an external review of the carrier's adverse decision or coverage decision involving medical judgment. Other coverage decisions of carriers regulated by the MIA can be appealed to the MIA under State law. The ACA's implementing regulations did not extend external review rights for coverage decisions based strictly on contractual language unrelated to any medical judgment.

IV. Carrier Reporting

The Appeals and Grievances Law requires carriers to submit quarterly reports to the MIA on the number of adverse decisions issued and the number and outcomes of internal grievances. The MIA then forwards this data to the HEAU for inclusion in this report. The data included in this report was not verified by the HEAU, but the HEAU notified the MIA where anomalies (missing quarterly data, outliers) were noted. Until recently, however, the carriers were not required to report on total enrollee numbers or total claims processed, so no proportional analysis of how frequently claims were denied was possible. 2024 Maryland Laws Ch. 891 (HB 1337) updated the reporting requirements, effective July 1, 2024, to include (1) the number of members entitled to health care benefits under a policy, plan, or certificate issued or delivered in the State

⁷ Throughout this report, we refer to the rights of patients during the appeals and grievances process. The Appeals and Grievances Law also gives health care providers and, pursuant to Chapters 3 and 4 of 2011, the patient's representative, if any, the right to file appeals and grievances on behalf of patients.

by the carrier (i.e., “enrollee numbers”); and (2) the number of clean claims for reimbursement processed by the carrier (i.e., “clean claim numbers”). For the first time, this report includes that carrier-reported data.⁸ This data reflects medical necessity denials in relation to clean claims, which excludes coverage denials and denials for administrative issues, coding errors, paperwork problems, and other non-specified reasons. As such, the value of the reported data is quite limited for the purpose of determining the percentage of claims that were denied; in a recent KFF report, only 6% of denials are based on medical necessity.⁹

2024 Maryland Laws Ch. 840 (HB 932) also updated the carrier reporting requirements, effective January 1, 2025, to include (1) whether the adverse decision involved a prior authorization or step therapy protocol; (2) the number of adverse decisions overturned after a reconsideration request; and (3) the number of formulary exception requests made and the outcome of those requests.

2025 Maryland Laws Ch. 669 (HB 848), effective October 1, 2025, further updated the carrier reporting requirements, requiring the currently reported data to be aggregated by zip code, and requiring carriers to identify instances when the number of adverse decisions has grown by 10% or more for any given service type in the immediately preceding calendar year or 25% in the immediately preceding three calendar years. Carriers are also required to explain the reasons for the increase.

Current data reveals that in the last ten fiscal years, on average, **only 10 percent of adverse decisions are challenged**, and on average, **55 percent of those grievances are reversed**. Given the low number of grievances filed and the percentage of positive outcomes that occur when a grievance is filed, the General Assembly updated denial notice requirements, effective October 1, 2025, requiring carriers to state at the top of all adverse and grievance decisions in “prominent bold print”:

- A. that the notice is a denial of a requested healthcare service;
- B. that the member may file an appeal (or complaint with the MIA);
- C. the carrier email and phone number dedicated for utilization review; and
- D. that the notice includes additional information on how to file and receive assistance for an appeal (complaint). 2025 Maryland Laws Ch. 669 (HB 848)

⁸ The enrollee and clean claims data reported by several carriers and provided to the HEAU indicated zero enrollees and zero clean claims. As of this reporting, it is unclear to the HEAU if that data indicates zero enrollees or clean claims, or a failure to report.

⁹ A [KFF report](https://www.kff.org/private-insurance/claims-denials-and-appeals-in-aca-marketplace-plans-in-2023/), *Claims Denial and Appeals in ACA Marketplace Plans in 2023*, analyzing federal transparency data released by the Centers for Medicare and Medicaid Services (CMS) on claims denials and appeals for non-group qualified health plans (QHPs) offered on HealthCare.gov in 2023, revealed that insurers of qualified health plans (QHPs) sold on HealthCare.gov denied 19% of in-network claims in 2023 and 37% of out-of-network claims for a combined average of 20% of all claims. The most common reason cited by insurers was “Other” at 34% followed by administrative reasons (18%), excluded service (16%), lack of prior authorization or referral (9%), and only 6% based on lack of medical necessity. <https://www.kff.org/private-insurance/claims-denials-and-appeals-in-aca-marketplace-plans-in-2023/>, (last accessed October 8, 2025).

Carrier Statistics FY 2025

In addition to the highlights below, statistical details from the data submitted by carriers appear in charts on pages 23-32 of this report.

1. Carriers reported 117,519 adverse decisions in FY 2025, 4,268 more adverse decisions than reported in FY 2024.
2. In FY 2025, consumers filed 13,221 grievances, challenging only 11% of the adverse decisions.
3. The largest percentage of denials were in the pharmacy (53%), lab/radiology (19%), and dental (14%) categories.
4. The largest percentage of grievances filed were in the pharmacy (38%), lab/radiology (17%), dental (15%), other (14%), and physician (8%) service categories.
5. Overall, in FY 2025, during the internal grievance process, carriers overturned or modified 56% of their original adverse decisions.
6. In FY 2025, 55% or more of home health (100%), other (71%), physician (58%), pharmacy (56%), and PT/OT/Speech therapy (56%) adverse decisions grieved were overturned or modified.

V. Maryland Insurance Administration (MIA)

The MIA has regulatory oversight of insurance products offered in Maryland. In 1998, the Appeals and Grievances Law was enacted by the General Assembly to provide a fair process for resolving disputes regarding the medical necessity of a proposed or delivered health care service. (*See*, Title 15, Subtitle 10A of the Insurance Article.) Until July 1, 2011, the Appeals and Grievances law applied only to individuals with insured health benefits. However, because of the ACA expansion of external appeal rights, effective July 1, 2011, the Department of Budget and Management for the State of Maryland, and effective June 28, 2013, Cecil County Public Schools elected to use the Maryland Insurance Administration's external review process to provide external review for their self-funded employee health benefit plans.¹⁰

When the MIA receives a written complaint from a member, a member's authorized representative, or a health care provider or facility, the MIA will review it to determine if the complaint raises issues subject to the Appeals and Grievances Law. If the Appeals and Grievances Law applies, the MIA confirms the insurance carrier's internal grievance process has been fully exhausted, unless there is a compelling reason for the MIA to act prior to the

¹⁰ While the MIA only conducts the external review for people with insured health benefits and the Department of Budget and Management for the State of Maryland and Cecil County Public Schools, with the exception of grandfathered plans, the ACA mandates external review processes for all group health insurance plans and health insurance issuers offering coverage in the group and individual markets. Grandfathered plans are subject to the external review process of adverse benefit determinations for claims subject to the cost-sharing and surprise billing protections of the No Surprises Act.

exhaustion process. If the carrier's internal process has been exhausted or if there is a compelling reason to bypass the internal grievance process, within five working days of receipt of the complaint, the MIA will contact the carrier to request a written response to the complaint. Unless an extension request from the carrier is granted by the MIA, the carrier shall respond to the MIA within seven working days (except emergency issues, which must be resolved within 24 hours), and the carrier must respond to the MIA by providing medical and claims information (including the health benefit contract) pertinent to the complaint and either uphold, reverse, or modify its denial. When the MIA does not have jurisdiction over the complaint or the carrier's internal grievance process has not been exhausted, the MIA refers the complainant to the HEAU so the member, the member's authorized representative, or the health care provider or facility can be assisted through the carrier's internal grievance process or external review process as applicable.

If the carrier upholds a denial that is subject to the Appeals and Grievances Law, then the MIA will prepare the case for review. As part of the preparation, the MIA will contact the complainant and the carrier in writing, giving them a deadline for submitting additional documentation to be considered in the review as applicable. Once the MIA receives the proper documentation, the case is then forwarded to an Independent Review Organization ("IRO") for a medical necessity review via the IRO's electronic portal. In selecting an IRO, the MIA ensures that the IRO has an appropriate board-certified physician available to review the case. Upon receipt of the case from the MIA, the IRO then transmits the case to its expert reviewer who researches and reviews the case, renders an opinion, and transmits the opinion back to the IRO. The IRO, in turn, conducts a quality review of the expert reviewer's opinion. For medical necessity reviews, the MIA asks the IRO to respond to specific questions as set forth in a cover letter attached to the complaint. The IRO will orally inform the MIA of the expert reviewer's determination and follow up with written determination via electronic mail. If the IRO reviewer's recommendation is to overturn, uphold, or modify the carrier's denial, the MIA may accept this recommendation and base its final closing letter on the professional judgment of the IRO reviewer. The complainant may be notified in writing of the outcome via electronic mail, U.S. mail, or facsimile. The MIA also forwards a copy of the IRO's medical opinion to the carrier via the MIA's licensee portal. In all instances, the carrier that is the subject of the complaint must pay the expenses of the IRO selected by the MIA. Hearing rights to contest the MIA decision are given to all consumers, except for individuals covered under the State of Maryland employee/retiree plan. Carriers do not have a right to an administrative hearing but may file a petition for judicial review.

Maryland law requires the MIA to make a final decision on complaints within 45 calendar days of receipt of the written complaint. However, the MIA can extend cases for an additional 30 working days if information requested by the MIA has not been received. For emergency or compelling cases, the MIA will conduct an expedited external review, completing the above process within 24 hours of receipt of the complaint. A hotline number (800-492-6116) is available 24 hours a day, seven days a week to respond to these emergency or compelling cases.

MIA Statistics FY 2025

MIA-provided data are reported on the charts and tables contained on pages 33-39 of this report. The data reflect only those cases where a disposition has been rendered; pending cases are not reported.

In addition to the data reflected in the charts and tables, the MIA-reported data reveal:

1. The MIA's Appeals and Grievances Unit received 1,110 complaints in FY 2025. After reviewing these complaints, the MIA determined that 475 involved MIA-regulated adverse decisions.
2. The MIA referred 76 complainants to the HEAU because the complainant had not yet exhausted the carrier's internal grievance process.
3. The MIA investigated 399 complaints in which complainants challenged the carrier's grievance decision. The MIA modified or reversed the carrier's grievance decision, or the carrier reversed its own grievance decision during the MIA's investigation in 267 cases (67%). The MIA upheld 132 (33%) of the carrier's initial decisions.
4. Like FY 2024, the largest percentages of grievances filed involved pharmacy services/formulary issues (46%); lab, imaging, and test services (16%); physician services (15%); and dental care (10%).

VI. Health Education and Advocacy Unit

The Maryland General Assembly established the Health Education and Advocacy Unit (HEAU) in 1986. The HEAU was designed to assist health care consumers in understanding health care bills and third-party coverage, to identify improper billing or coverage determinations, to report billing or coverage problems to appropriate agencies, including the Consumer Protection Division's Enforcement Unit, and to assist patients with health equipment warranty issues. Based upon the HEAU's successful efforts in these areas, the General Assembly selected the HEAU to be the State's first-line consumer assistance agency when it passed the Maryland Appeals and Grievances Law. Following passage of the ACA and the implementation of Maryland's Health Benefit Exchange, the HEAU began helping consumers who encountered problems enrolling on the Exchange and obtaining premium tax credits and cost-sharing reductions.

The Appeals and Grievances Law requires carriers to notify patients that the HEAU is available to assist them in mediating and filing a grievance or appeal of an adverse decision or coverage decision. The notice must also include the HEAU's address, telephone number (410-528-1840), facsimile number (410-576-6571), and email address (heau@oag.state.md.us).

When the HEAU receives a request for assistance, the HEAU gathers basic information from the carriers related to the services or care denied. Specifically, the HEAU asks the carrier to provide a copy of the insurance contract provisions and the utilization review criteria upon which the carrier based the denial and to identify precisely which provisions or criteria the patient failed to meet. Carriers must provide the requested information to the HEAU within seven working days from the date the carrier receives the request. The HEAU also gathers information about the patient's condition from the patient and the patient's provider to determine if the patient meets established criteria and assess whether the denial is incorrect. The HEAU presents this information to the carrier for reconsideration of the denial. Many complaints are resolved during this information exchange process. If not resolved, the HEAU will prepare and file a formal written grievance or appeal with the carrier on behalf of the patient.

If, at the conclusion of the internal appeals and grievances process, the carrier continues to deny coverage for the care, the HEAU prepares an external appeal of the carrier's decision. The HEAU forwards the case to the MIA or other external entity with a copy of all relevant medical and insurance documentation, and the HEAU monitors the outcome of the external review.

A. *HEAU Statistics FY 2025*

The HEAU Appeals and Grievances data¹¹ are reported in the charts and tables contained on pages 40-57 of this report. The data reflect medical necessity, contractual, and eligibility denials. Because newly filed cases contain incomplete data, this report includes only those cases the HEAU closed during FY 2025.

The HEAU closed 2,068 cases in FY 2025.

1. 39% of the complaints closed by the HEAU involved “carriers,” defined in this report to include insurers, nonprofit health service plans, HMOs, dental plan organizations, third-party administrators, utilization review agents, pharmaceutical benefit management companies, and any other entity that provides health benefit plans or adjudicates claims.
2. 8% of the complaints closed by the HEAU involved consumers requesting assistance with Maryland Health Connection-related issues.
3. 712 of the complaints closed by the HEAU were cases involving appeals and grievances. Not all of the 712 appeals and grievances complaints filed with the HEAU were mediated. Some consumers, or other persons acting on their behalf, file complaints but never complete an authorization to release medical records form or an authorized representative form (for Maryland Health Connection cases), which the HEAU requires to mediate the case. Other complaints are filed for the record only or are referred to a more appropriate agency. Of the 712 appeals and grievances cases the HEAU closed during FY 2025, 449 (63%) involved assisting consumers with mediating or filing grievances of adverse or coverage decisions. Some of the 449 cases involved more than one carrier.
4. Of the 449 appeals and grievances cases the HEAU mediated during FY 2025, 29% were adverse decision (*medical necessity*) cases, 61% were coverage decision (*contractual exclusion*) cases, and 10% were eligibility cases.
5. As a result of the HEAU mediation process, 52% of the medical necessity cases, 47% of the coverage decision cases, and 57% of the eligibility denial cases were overturned or modified.
6. HEAU mediation efforts resulted in a decision change in 51% of cases involving at least one MIA-regulated plan. In cases involving non-regulated plans, the HEAU's efforts resulted in a decision change 49% of the time.

¹¹ Detailed data related to the outcomes of cases handled by the HEAU unrelated to the Appeals and Grievances Law are not contained in this report; some general complaint numbers and categories are reported for informational purposes.

7. In FY 2025, the HEAU assisted patients in recovering or saving nearly \$2.6 million dollars, including over \$1.6 million in appeals and grievances cases.

B. Appeals and Grievances Successes

Consumers continue to receive significant benefits from Maryland's Appeals and Grievances Law and HEAU assistance. When carrier denials were challenged by the HEAU, 50% were overturned or modified during the reporting period. Positive results for the consumers who reach HEAU notwithstanding, this reversal rate suggests carriers are inappropriately denying claims in the first instance, and the resulting delays burden consumers medically, financially, and emotionally.

Some examples from cases mediated by the HEAU this year highlight the importance of consumer assistance when challenging claim payment avoidance by carriers and health care claim denials.

1. A consumer was experiencing severe back pain that required surgery. The pain was so intense that he had to rely on narcotic medications, which impaired his ability to function. His carrier denied coverage for the surgery, finding it not medically necessary. In his complaint to the HEAU, the consumer stated, *"I am at a point where I can no longer work full time. I need the surgery, or I will have to go on disability, which I really do not want to do."* The surgical delay *"is causing extreme pain (I was in the ER on [...] because I could not get the pain under control even with oral medication. I am currently taking 4 oxycodone and 2 tramadol per day. This is causing many other health issues (confusion, dizziness, slurred speech, constipation, stomach issues, etc.) that leave me unable to work full time and often unable to function in any normal way."* The HEAU submitted a second-level internal appeal, but the carrier upheld its adverse decision. The HEAU submitted an external appeal to the MIA. The denial was overturned on external appeal, and the consumer was able to undergo the necessary back surgery. He has since reported significant physical improvement and a better quality of life.
2. A consumer was admitted to the hospital for treatment of a tongue laceration. During the hospital stay, the consumer also experienced alcohol withdrawal and was treated for both conditions. The consumer had a supplemental indemnity plan, and the family filed a claim, with supporting hospital records, under that plan. The claim was denied based on an exclusion that stated coverage would not apply if the patient was admitted while intoxicated or under the influence of drugs. However, the consumer had entered the hospital sober following a fall, and a toxicology report at admission confirmed a blood alcohol level of zero. Despite this evidence, the carrier continued to deny the claim. The HEAU intervened, challenging the denial, and the carrier ultimately reversed its decision, saving \$12,000 for the family.
3. A consumer was diagnosed with a serious blood cancer in early adulthood. After trying conventional treatments that were both ineffective and caused severe side effects, the consumer sought alternative care from a provider in another state. As part of monitoring treatment progress, the provider ordered a BCR-ABL1 genetic test – an essential tool

for tracking the effectiveness of treatment and detecting potential disease progression. The carrier denied coverage, citing a requirement for prior authorization through a third-party utilization management company. The HEAU intervened, challenging the denial because there was no language in the certificate of coverage requiring the patient or provider to obtain prior authorization from that entity. The carrier issued a one-time exception, covering the testing and saving the consumer \$4,000.

4. The parents of a young child with developmental delays contacted the HEAU because their carrier was repeatedly processing therapy claims incorrectly as “rehabilitative” rather than “habilitative.” Despite the parents’ ongoing efforts to have the claims processed correctly, the carrier continued to deny coverage for necessary habilitative services, even though the medical records clearly supported the need. HEAU assisted with two appeals, successfully advocating for the claims to be reprocessed and paid in both instances, saving the family \$8,974.
5. A pediatric consumer was transferred from the emergency room to inpatient psychiatric care within the same hospital – just two floors apart. While the rest of the hospital was in-network, the psychiatric unit was out-of-network, a fact that was not disclosed to the consumer’s parent at the time of transfer. The claim for services was processed by the carrier as out-of-network, requiring the family to meet their \$10,000 out-of-network deductible and other out-of-network cost sharing obligations, rather than as in-network as required by the No Surprises Act. The HEAU intervened, challenging how the claim was processed; all claims were ultimately processed as in-network, saving the family \$23,500.
6. A consumer contacted the HEAU after her preventive well-woman visit was initially covered by her carrier, but payment was retracted nearly nine months after the appointment. The consumer was advised by her carrier that she received covered services but that there was an error in the documentation submitted by her provider, and that the provider should not bill her. Despite that, the provider began billing the consumer and eventually referred the balance to a collection agency. The consumer was stuck in the middle of a paperwork dispute between her provider and carrier, and despite her repeated efforts to resolve the issue herself, she was unsuccessful. The HEAU intervened and the carrier overturned the denial, saving the consumer nearly \$2,000.

These examples demonstrate the value of HEAU’s assistance when consumers obtain it. However, mediation continues to be a back-end solution. Health claim denials, particularly when unwarranted, harm consumers by delaying necessary care, risking consumer health and the financial stability of their households.

C. Additional HEAU Activities and Data

The HEAU also assists consumers with medical billing, equipment, and records disputes; problems enrolling on the Exchange and obtaining premium tax credits and cost-sharing reductions; and obtaining financial assistance and income-based payment plans from hospitals.

In FY 2025, the top ten categories in which the HEAU received the largest number of non-appeals-related cases were:

- Assistance Request - Consumer Requesting Information or Response to Question
- Billing - Patient Believes that Charges are Too High
- Quality of Care - Consumer Displeased with Quality of Care
- Billing - Failure to Refund Overpayment
- Billing - Consumer Seeks Itemized Bill or Clarification of Charges
- Billing - Billed for Services Not Performed
- Billing - Billing for Charges Already Paid
- Medical Records - Patient Requesting Copies of Medical Records
- Billing - Charging in Excess of Estimate
- Assistance Request - Consumer Requesting Charity Care

The HEAU continues to monitor and offer consumer-centric input to state and federal agencies involved in health policy decision making. The HEAU's director or deputy director served as a consumer representative, either as a member or in an *ex officio* capacity, on the Maryland Health Benefit Exchange's Standing Advisory Committee, the Protected Health Care Commission, and the Health Services Cost Review Commission's Facility Fee Workgroup.

The HEAU also provided consultative and litigation support to the Office of the Attorney General in its efforts to advance and defend the consumer protections afforded to Marylanders by the Affordable Care Act and other federal laws, joined amicus briefs, and commented on federal and State regulations supporting efforts to enhance consumer protections in the health care marketplace.

D. Areas of Concern

1. Hospital Facility Fees

During the 2019 and 2020 sessions, the HEAU sought legislation to address the growing prevalence of hospital outpatient facility fees and the financial harms consumers suffered due to these surprise charges. Ultimately, the Facility Fee Right to Know Act was passed, requiring that consumers be given specific statutorily proscribed notice of a small subsection of the outpatient fees. Md. Code Ann., Health Gen. § 19-349.2. The HEAU advocated for a statutory notice for all outpatient facility fees but in a last-minute amendment, hospitals sought and obtained a significant limitation, requiring that statutory notice be provided only to consumers scheduled for "clinic services" that aren't otherwise billed in another rate center. Consumers continue to be blindsided by surprise facility fees when they obtain the following types of services:

- a. Diagnostic Radiology, Ultrasound, and Vascular
- b. Nuclear Medicine
- c. Radiology Therapeutic
- d. Electrocardiography
- e. Electroencephalography
- f. Physical Therapy & Occupational Therapy
- g. Respiratory Therapy & Pulmonary Function Testing

- h. Leukapheresis
- i. Labor and Delivery
- j. Interventional Radiology/Cardiovascular
- k. Ambulance Services – Rebundled
- l. Speech Therapy
- m. Audiology
- n. Laboratory Services
- o. CT/MRI

At the time, Maryland was one of only a few states to address these burgeoning fees, but state and federal lawmakers and consumer advocacy groups across the country are pursuing reforms to reduce the surprise and the consumer and employer health care costs associated with facility fees. Georgetown University’s Center on Health Insurance Reforms recently published two reports, [*Regulating Outpatient Facility Fees: States are Leading the Way to Protect Consumers*](#), July 2023,¹² and [*Facility Fee Reforms: How States are Tackling Excessive Charges*](#), June 2025,¹³ exploring why and how many states are taking on the regulation of these fees.

During the 2024 session, the OAG sought legislation requiring a statutory notice be provided for facility fees billed in the rate centers outlined above, and by out-of-state hospitals billing facility fees in Maryland outpatient settings. As a result, the HEAU is participating in a Health Services Cost Review Commission (HSCRC) led workgroup established by [*SB 1103*](#) tasking the HSCRC to report further on expanding statutory notice requirements, and provide research on the impact, purpose, and feasibility of continued facility fee charges.

In December 2024, in its Report on [*Facility Fees and Facility Notices*](#),¹⁴ the HSCRC recommended requiring all non-profit and for-profit hospitals providing outpatient services in the State, whether or not the hospital’s rate is regulated by the HSCRC, to provide notice of facility fees for outpatient services that are:

- Provided in the State of Maryland; and
- Have both a hospital charge (facility fee) and a professional charge.

But it recommended waiting until the 2026 session to allow the HSCRC to complete the evaluation of the effectiveness of the current notice. The HSCRC’s recommended expansion of the notice included a carve out for inpatient services, emergency department services, emergent services, laboratory/pathology services and professional fees.

The HEAU fully supports expansion of the notice but disagrees with the recommendation to carve out laboratory/pathology services because consumers often face higher cost sharing for hospital-based labs and don’t expect to face facility fees for such services. The HEAU believes that consumers who visit hospital outpatient settings should not be blindsided by unexpected

¹² <https://chir.georgetown.edu/new-georgetown-report-and-issue-brief-on-outpatient-facility-fee-billing-and-state-policy-responses/>, (last accessed October 8, 2025).

¹³ https://www.youtube.com/watch?v=78MpXSbNjCo&embeds_referring_euri=https%3A%2F%2Fchir.georgetown.edu%2F, (last accessed October 8, 2025).

¹⁴ [https://dlslibrary.state.md.us/publications/Exec/MDH/HSCRC/SB1103Ch142\(2\)\(2024\)_2024.pdf](https://dlslibrary.state.md.us/publications/Exec/MDH/HSCRC/SB1103Ch142(2)(2024)_2024.pdf), (last accessed October 8, 2025).

charges and supports expanded notice. Indeed, blindsiding patients with charges is inconsistent with the requirements of the Consumer Protection Act. This issue has urgency for consumers because the burden of paying the fee out-of-pocket falls disproportionately on underinsured patients, who are least likely to be able to afford it.

HEAU Facility Fee Related Complaints

These excerpts from consumer complaints filed with our office offer the consumer's perspective regarding these types of surprise bills.

- a. "I visited [...], MD MPH for the MRI result. For the MRI, [I] have the \$100 copay. I also paid \$25 for the Dr. visit copay. I got the \$247.36 bill. The representative explained \$100 is for MRI copay, \$147.36 is for the building entrance fee. Because Dr.'s office is in the building, the patient needs to pay the entrance fee for that building. It is ridiculous, and the Dr. should pay the office rent fee for the building and not ask the patient for this. We never heard patient needs to pay the building entrance fee."
- b. "This was a routine annual office visit with my in network primary care physician... I have full insurance coverage..., I'm utilizing my in network PCP provider [...]. I paid my \$35.00 copay at time of visit. However, [...] is charging me a hospital facility fee. I've never been admitted to the hospital so they shouldn't be billing me these hidden fees. My insurance has paid their portion of the actual services provided. These inappropriate charges and billing practices should be reviewed..." (\$129.39 fee applied to consumer's deductible).
- c. "I was never told that a facility charge would apply to this outpatient visit when I scheduled an appointment. I have also not been provided copies of my consent to be charged this facility fee." (Out-of-state hospital with in-state clinic. Clinic fee of \$178 and radiology fee of \$1,736.)
- d. "I had this procedure done two other times billed as an in-office procedure with the co-pay for an office visit of \$40. On [...], however, it was billed as outpatient surgery by [...]. The office was NOT transparent about the change in billing. There was a charge for the physician and medical services totaling \$530. Insurance paid \$328.10, I paid \$161.90. It was unexpected since the in-office procedure was previously covered by the co-pay. Then I received an additional bill with a minor surgery fee and a diagnostics fee, totaling \$602.43. Insurance paid \$67.17 and I have not paid the balance of \$535.26, but am disputing these charges. I was ONLY in the office. Never an operating room. There was no biopsy done. The difference seems to be that the office or [...] is now changing the insurance coding to get paid as outpatient surgery from a medical facility instead of an in-office procedure. They did not say this when I made the appointment or came to the appointment."
- e. "I visited an in-network doctor on [...]. Her office is within a hospital and my insurance covered the visit after I paid my copay. The Dr. sent me to get blood work drawn at the lab within the hospital and I received that on the same day as the Dr. visit. My bloodwork was coded as an Outpatient Hospital charge and my Dr. visit was coded as an in office charge. The lab work resulted in a bill of \$811.98 but if it had been coded

as in office, I would have had to pay a copay of \$40.00. I called my insurance and they said that I needed to call the Dr. office to change the way the bill was coded. I spoke to the facility today and they said that their system would not allow them to change the code from out patient to in office.”

2. Other Out-of-Network Facilities

The HEAU continues to receive complaints from consumers who are referred by an in-network provider to an out-of-network facility for services. Consumers receive services at these facilities without realizing that they are out-of-network and therefore have incurred bills much higher than they would have incurred at an in-network facility. Some facilities provide no out-of-network notice, while others have consumers sign forms that say the facility might be out-of-network. But consumers sign many forms when they present for services without having the opportunity to carefully read them or having the opportunity to edit them in any way. This is a concern that is expected to be addressed by the Good Faith Estimate, Advanced Explanation of Benefits provisions in the federal No Surprises Act once the regulatory process is complete, but it is unclear when or if that process will be completed. Although the Consumer Protection Act prohibits providers from failing to provide material price information, the HEAU recommends offering additional clear statutory protection to Marylanders now, which should include, at a minimum, requiring out-of-network facilities to provide pre-appointment, stand-alone notice regarding the facility’s out-of-network status and detailed cost estimates for planned services.

HEAU Out-of-Network Facility Related Complaints

The complaint summaries below are a small snapshot of the types of complaints the HEAU has handled regarding these types of surprise bills.

- a. A consumer was having a hiccup crisis. After researching available in-network providers, the consumer had a consultation with a gastroenterologist, who advised him he needed an urgent esophagogastroduodenoscopy (EGD), which was scheduled two days later at the physician-owned ambulatory surgery center (ASC) in the same building as the gastroenterologist. At his initial appointment, he provided his insurance information and signed several documents on a tablet. He was given a brochure outlining the steps needed to prepare for the surgical procedure.

The next day, he received a text message seeking payment of his \$500 deductible prior to the surgery. He contacted the provider and asked why he was facing a \$500 deductible because he had no deductible for in-network services. He was told to contact his carrier. When he did so, he was advised that the ASC was out-of-network with his plan, even though it shared the same address as the provider, and that the ASC’s claims would apply toward his out-of-network deductible. He was further advised to check back with the ASC because it was possible the ASC was in-network under another identifier. When he contacted his provider to seek an alternative surgical location, he was assured that he would only be responsible for \$138. After making clear that he didn’t want any surprise bills, and receiving assurances that he would not, he decided to proceed with the scheduled surgery and paid the agreed upon charge of \$138 on the morning of his procedure.

The ASC submitted a claim to his carrier, billing \$21,325. His carrier allowed \$1,500.81 (300% of the Medicare rate), paying \$720.65 to the ASC after applying \$600 to the consumer's out-of-network deductible and \$180.16 to the consumer's co-insurance. The consumer was subject to balance billing for the remainder.

The consumer said this to the HEAU: "When I first saw the original amount that was due (over USD 19k), I couldn't sleep well. It seemed like a nightmare, or a prank. I was afraid of having to call a lawyer, and last case scenario, spend my reserves to pay for this. I also felt ashamed and betrayed by the provider. If they had been upfront with me, as I requested, about prices and what I had to pay, I would have made different choices. And then, they told me that all I had to pay was what I paid on the day of the procedure - and thought with this I would be safe."

The ASC ultimately issued a statement to the consumer seeking payment of \$1,617.72.

- b. A consumer was experiencing severe upper GI distress, coupled with hematemesis. She utilized ZocDoc to find an in-network provider and booked a next day, "in-network" appointment, with a gastroenterologist. The doctor advised her to have an EGD without delay. He emphasized the need for an expeditious appointment for the procedure. She was told to go next door to set up the appointment for the procedure. She didn't leave the building but went to an adjacent office. The consumer stated to the HEAU that it "looks like the same office/operation." While she was setting up the surgical appointment, she was told by the person at the desk that her carrier was contacted, and that her copay was \$500. She was not informed that the ASC was not a participant in her health plan. There was no further discussion of cost share. She was "under the impression" that she was responsible for \$500 and no more.

On the morning of the procedure the consumer paid \$500 and was assured by the person checking her in at the front desk that this payment was "her share," per the advice of her carrier. She was also asked to sign documents on a tablet. She noticed that one was a Promissory Note, and one was an Assignment of Benefits form. She asked the person checking her in why the forms were required, if the ASC was in-network with her plan. She was told not to worry "that it was an insurance requirement."

The ASC submitted a claim to her carrier, billing \$21,325. Her carrier allowed \$507.80 (110% of the Medicare rate), all of which was applied to the consumer's out-of-network deductible. The consumer was subject to balance billing for the remainder.

The ASC ultimately issued a statement to the consumer seeking payment of \$1,500.

- c. A consumer had been experiencing stomach pain for several months and was very concerned, as he had lost a family member to stomach cancer. He utilized ZocDoc to find an in-network gastroenterologist. The doctor advised him to have an EGD and was told by the provider that the procedure should be free for him. He scheduled the procedure at the provider-owned ASC. Two days before the procedure he was advised that his out-of-pocket cost would be \$492, and that he would have to pay that amount when he arrived for the procedure. The patient advised the HEAU that "I had already been dealing with stomach pain for several months and my [...] died of stomach cancer,

I didn't want to determine if there was a better option or that they were overcharging me.” On the day of the procedure, he paid the \$492 quoted.

The ASC submitted a claim to his carrier, billing \$21,325. His carrier allowed - \$750.40; all but \$30.24 was applied to the consumer’s out-of-network deductible and coinsurance. The consumer was subject to balance billing for the remainder.

The consumer advised the HEAU, “If [...]’s practice or [the ASC] was out of network, they never informed me of it either.... If I'd had any idea that the final charges would have been at that level, I would have seriously second guessed moving forward with the procedure or would have sought out another provider. This feels like I've been failed by and taken advantage of by multiple entities compared to what I was told.”

The ASC ultimately issued a statement to the consumer seeking payment of \$ 1,324.76.

3. Financing Products for Medical Expenses

During the 2025 legislative session, the Maryland General Assembly enacted important protections to limit the impact of medical debt on consumers’ homes and credit reports. 2025 Laws of Maryland, Ch. 498 ([HB428](#)) protects a consumer’s primary home from forced sale due to medical debt, and 2025 Laws of Maryland, Ch. 121 ([HB1020](#)) restricts the reporting of some medical debt on credit reports – both aimed at reducing the risk of foreclosure or long-term credit damage when individuals seek necessary but expensive health care.

However, despite growing reliance on health care credit cards and other financing products to cover medical expenses, significant consumer protection gaps remain. These financial products are often introduced at the point of care – sometimes when patients are in pain, under anesthesia, or facing urgent medical decisions – raising serious concerns about informed consent and financial vulnerability.

According to a recent *JAMA* study, [Prevalence of Medical Credit Cards by Specialty](#), (April 11, 2025),¹⁵ health care providers are increasingly promoting medical credit cards and loans such as Alphaeon (Comenity Capital Bank), CareCredit (Synchrony Financial), and Wells Fargo Health Advantage as solutions to rising health care costs. These products are often introduced at the point of care where consumers may lack the resources, time, or financial literacy to fully understand the terms, seek additional information, or explore alternative options.

The providers and staff promoting these products are not financial professionals, but they have been “trained” to market the financial products as affordable solutions without fully disclosing the deferred interest clauses, high APRs (averaging 26.99%), or risk of ballooning debt. According to a recent Consumer Financial Protection Bureau report, [Medical Credit Cards and Financing Plans](#), (May 1, 2023);¹⁶

¹⁵ <https://pmc.ncbi.nlm.nih.gov/articles/PMC11992600/> (last accessed, October 1, 2025).

¹⁶ https://files.consumerfinance.gov/f/documents/cfpb_medical-credit-cards-and-financing-plans_2023-05.pdf (last accessed, October 1, 2025).

- “People paid \$1 billion in deferred interest payments for these health care charges from 2018-2020. People used cards or loans with deferred interest terms to pay for almost \$23 billion in health care expenses, and over 17 million medical purchases, from 2018 to 2020.
- “From 2017 to 2020, the share of medical borrowing on deferred interest grew relative to other deferred interest borrowing. This is true across all ranges of credit scores.”
- “CFPB analysis indicates that, between 2015 and 2020, people incurred interest on 20 percent of their healthcare purchases when using deferred interest cards or loans. People with credit scores below 619 incurred interest more frequently, for about 34 percent of their health care purchases. In part, people with lower credit scores may have been more likely to incur interest because they were more likely to have shorter periods before they were charged deferred interest.”

For those who do not understand the terms, which is common in these high-pressure encounters, the cost of services substantially exceeds the cost of other available credit, further increasing medical debt burdens.

The findings in these reports are reflected in the consumer complaints received by the HEAU. The HEAU has received numerous complaints from consumers caught in the predatory trap of high-interest or deferred-interest medical credit cards and loans, often without realizing they had a loan in the first instance. Often, we see that the provider gets paid immediately by the lender, even for services not yet provided, and the patient is issued the credit. This arrangement presents many risks to the patient, including:

- **Paying for unreceived or incorrect services:** Because the provider is often paid upfront and in full, patients don’t always appreciate that they can challenge the amounts due for services not provided, or for inadequate or incompetent services. Some providers take full payment upfront and have consumers sign no refund contracts.
- **Waived insurance benefits:** Often services may be covered by insurance, with protections for balance billing under the terms of the provider contract or the No Surprises Act. Patients may not appreciate that paying with a medical financing product before the insurance process is complete makes recouping improper or overpayments more difficult.
- **Financial Assistance:** Patients may not realize they may be eligible for charity care or financial assistance based on income level. Paying with a medical financing product might make it harder to receive financial assistance.

HEAU Medical Financing Related Complaints

The complaint summaries below are a glimpse into the types of complaints the HEAU has handled regarding these types of financing products.

- a. In 2020, a dentist permanently surrendered his dental license in Maryland. His business model was to obtain significant prepayments for future dental services, often through a financing company offering high-interest deferred payment loans. The HEAU received over 90 complaints from consumers who had failed to receive prepaid dental services, in whole or in part; had incompetently performed dental services that needed to be corrected; or were just trying to get copies of their medical records/dental appliances. The HEAU was able to obtain refunds or waivers of outstanding balances from the lending companies in many cases, saving over \$300,000 for consumers.
- b. Recently, two men's erectile dysfunction clinics abruptly closed their doors. Their business model was to obtain significant prepayments for future services, often through a financing company offering high interest deferred payment loans. The HEAU has received over 30 complaints from consumers who failed to receive the prepaid erectile dysfunction treatments, in whole or in part, or who reported that the partial treatments they were able to receive before the office closure were ineffective. Some of their stories reveal many of the problems consumers face with these financial products, and the relief the HEAU was able to obtain for them during our mediation process.
 - i. "[I] answered a radio ad for ED treatment stating a loan could be set up with a 24 month 0% grace payoff period. I signed up but the loan of 5K was not sent to me for dispersal but directly to [clinic]. I got 6 of 18 promised treatments before the clinic closed. Now the loan servicer wants me to pay all 5k. I offered to pay for the treatments I received as stated in their loan agreement wording. They refused." *The HEAU intervened with the lender, which ultimately waived the loan entirely.*
 - ii. "I first learned about a promising potential treatment for erectile dysfunction advertised on the radio.... I reached out and made an appointment to go to their offices... When I went in and completed their intake paperwork, I recall that they did not bother with trying to bill my insurance provided through my employer. I believe they presented me with an alternative method, to pay for the treatments by taking out a loan that I would have to pay at a later date. Desperate for help, I readily agreed to their terms... I left, then returned twice...After the second session, I decided not to return again, since I felt that nothing medically significant was occurring, and I left feeling deeply disgusted/repulsed, and frustrated at the lack of meaningful results. Two years later, [bank] started to send me a series of harassing emails, telephone calls, and bills, demanding that I pay them back a total of \$8,280.60 (plus "past due" interest of \$436.76)....This experience felt like a scam from the outset, but I was so desperate for help that I ignored my inner doubts in the hopes of finding a real solution. They preyed on me and many other men who I saw in their lobby... They should not be allowed to get away with offering fraudulent medical services to desperate people, then billing us such exorbitant fees. I simply cannot afford to pay this amount. I am barely making ends meet... I hope you can help me." *The HEAU intervened with the lender, which ultimately waived the loan entirely.*

- iii. A consumer saw television advertisements for treatments to improve erectile dysfunction and scheduled a free consultation to learn more about the clinic's services. During the consultation, the consumer was provided with "a stack of papers, some of which [he] did not understand" and were not explained to him. The following day he decided not go forward with the treatment, "because it was too expensive, and [he was] on a fixed income, and [could] not afford it." He contacted the clinic by phone and requested that they cancel his loan application for the services. The clinic refused, despite the fact that he had received no planned services. By the time the consumer contacted the HEAU, his \$5,200 loan had ballooned to \$7,019. *The HEAU intervened with the lender, which ultimately waived the loan.*
- iv. Another consumer saw a special on the news regarding treatments being provided at the clinic. After receiving his consultation and agreeing to move forward with the services, someone in the office completed loan paperwork for him and he signed the documents. He was not provided with a copy of any documents and was unaware the full amount of planned services would be paid to the provider upfront. He began treatments, but then he "would go to the clinic and it would be closed without notice. Now they cannot be found." He attempted to have his loan waived but was unsuccessful and his credit report was negatively impacted. *The HEAU intervened with the lender, saving the consumer \$5,601.94.*
- v. Another consumer scheduled an appointment at the clinic after learning about a free trial on a television broadcast. After coming in for the consultation and requesting the free trial, the consumer was asked to sign a stack of documents, including a loan application, and "was told [he] would receive a copy later." Later, he received a digital copy of the documents that detailed the terms of the loan. The consumer contacted the lender to decline the loan, having received no treatments beyond the advertised free initial consultation. The bank refused and directed the consumer back to the clinic. The clinic refused to issue a refund. The consumer contacted the HEAU asking the "medical clinic to return the money they received for nothing given." *The HEAU intervened with the lender, saving the consumer \$4,500.*
- c. Similarly, Smile Direct Club, a telehealth company that offered dental services, filed for bankruptcy in September 2023, but continued to charge consumers for services after it abruptly ceased operations. Many consumers financed their aligner treatment through a "SmilePay" program, which generally required 26 monthly installment payments. Despite closure, consumers, including those who had not completed their treatment, were advised they were required to continue to make the installment loan payments. The [NY Attorney General's](#) office intervened, and an agreement was reached whereby consumers who were improperly charged will receive refunds.
- d. In another dental case, a consumer needed extensive dental work and applied for a \$40,000 loan facilitated by the dental office. The dentist was paid in full, upfront for the planned treatment. After the consumer's third visit, the dentist disappeared, leaving her with incomplete dental work. The consumer continued to make \$801.33 monthly payments on the loan to avoid negative credit reporting. She attempted to take legal action against the provider but was unable to locate her. The HEAU intervened and the

lending company refunded/waived \$ 30,089.50; the consumer's dental record indicated the consumer had received \$9,910.50 in services.

- e. A consumer in need of hearing assistance turned to a hearing aid company in May, hoping the devices would improve her quality of life. After receiving the hearing aids in June, which were sold with a three-year warranty and lifetime service and aftercare, she quickly realized they were not the solution she had hoped for. The devices were uncomfortable, did not fit properly, and failed to improve her hearing. Despite her concerns, she gave the company a chance to make things right. In July, the company replaced the hearing aids, but by September, the problems persisted. The new devices caused itching in her ears, produced an echo, and overwhelmed her eardrums. These issues made it difficult to wear the hearing aids for any extended period. After months of frustration and no resolution, the consumer made a final visit to the provider in October and decided to return the devices altogether. The provider refused the return and refused to issue a refund.

What made this situation even more stressful was the financial burden. To afford the \$5,979 hearing aids, the consumer had applied for financing offering a 48-month low APR payment plan at 9.99%. Even with the promotional interest rate, she was paying nearly \$50 per month in interest alone. The terms of the agreement stated that if the balance of \$5,725.50 was not paid in full by the end of the 48-month period, the remaining balance would be subject to a 28.99% *APR*.

The HEAU intervened with the hearing-aid company, which agreed to facilitate the cancellation of her financing and issue a refund, contingent on the return of the hearing aids, saving the consumer \$6,129. This consumer's experience highlights the risks that come with financing essential medical devices. She initially sought only to improve her hearing but instead found herself entangled in a stressful financial commitment for a product that didn't work. Had the company not agreed to a refund, she could have been saddled with thousands of dollars in debt for a device that failed to meet her needs.

We've also received similar complaints from consumers seeking treatment at MediSpas. These cases illustrate the risks that come with financing medical services and devices, and the need for Maryland to close the loophole in its medical debt protections and ensure that all health care-related financing, regardless of the lender or credit product, is subject to consumer safeguards. Without action, more Marylanders will fall into the trap of mounting debt, which will further limit access to quality, affordable care. Without federal oversight, and with the Consumer Financial Protection Bureau (CFPB) deprioritizing medical debt enforcement, state-level action is urgently needed.

The National Consumer Law Center's February 25, 2025 Issue Brief, [What States Can Do: Medical Credit Cards and Other Medical Lending Products](#), offers information about what other states have done to protect their consumers from these harms. At a minimum, the HEAU recommends:

- Prohibiting providers and staff from filling out a third-party credit application for patients.
- Prohibiting providers and staff from providing patients with an electronic device to apply for financing.

- Prohibiting providers from promoting, advertising, or otherwise marketing financing products in treatment rooms, during treatment, or when the patient has been administered or is under the influence of general anesthesia, conscious sedation, or nitrous oxide.
- Prohibiting providers from charging treatment or costs to a financing product before the date upon which the treatment is rendered or costs are incurred.
- Prohibiting providers from charging treatment or costs to a financing product when such charges are prohibited by Medicaid, Medicare, private insurance contracts, balance billing laws, or the No Surprises Act.
- Prohibiting providers from charging treatment or costs to a financing product when such charges could be eligible for hospital financial assistance or income-based payment plan protections.
- If foreclosure protections or credit reporting safeguards do not apply to a financing product, providers must inform patients – each time the product is used – of the rights they are waiving by using that product to pay for services.

4. Additional Concerns

The HEAU also has concerns about providers who (a) require pre-treatment payments of deductibles and coinsurance; (b) fail to refund overpayments; (c) fail to provide reasonable refund policies for cancelled appointments; (d) refuse to provide service without obtaining a credit card “on file” with authority to charge unspecified amounts; (e) fail to provide requested medical records; (f) submit claims with incorrect diagnostic codes that result in greater patient cost-sharing; (g) abandon medical records; and (h) charge insured patients administrative fees for services integral to the provision of health care.

The HEAU continues to receive complaints from consumers unaware of their right to obtain hospital financial assistance and income-based payment plans, which include concerns about hospitals setting unrealistic and unaffordable monthly payment plans. During the reporting period, the HEAU worked with one hospital system to ensure income-based payment plans were offered to consumers who had not been offered the plans.

VII. Conclusion

The Maryland General Assembly continues to advance legislation to protect consumers from unscrupulous behavior in the health care marketplace, often over the objections of some other market participants who seek to maximize profits. The HEAU looks forward to continued partnership with elected officials and others who seek to lead and innovate in the health care marketplace to provide all Marylanders with timely, transparent, affordable, and high-quality care.

Appendix

**Carrier Cases
Adverse Decisions, Grievances and Outcomes**

Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overturned/ Modified
Aetna Dental Inc.	611	0	1	0%	100%
Aetna Health Inc. (a Pennsylvania corporation)	928	16	250	56%	44%
Aetna Life Insurance Company	979	34	287	56%	44%
Ameritas Life Insurance Corp.	836	0	413	59%	41%
CareFirst BlueChoice, Inc.*	31,988	0	3,252	51%	49%
Carefirst of Maryland, Inc.	12,930	0	1,398	36%	64%
CIGNA Health and Life Insurance Company	26,033	0	712	49%	51%
Colonial Life & Accident Insurance Company	67	0	0	0%	0%
Delta Dental Insurance Company*	14	0	5	80%	20%
Delta Dental of Pennsylvania	59	12	16	44%	56%
Dental Network, Inc.*	2	0	2	100%	0%
Dentegra Insurance Company*	14	0	2	0%	100%
Dominion Dental Services, Inc.	2,180	0	121	57%	43%
Golden Rule Insurance Company	23	0	6	83%	17%
Group Hospitalization and Medical Services, Inc.	10,622	0	994	45%	55%
Guardian Life Insurance Company of America	1,244	0	742	54%	46%
Independence American Insurance Company	0	0	1	100%	0%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	2,107	3	200	76%	24%
Kaiser Permanente Insurance Company*	10	0	4	50%	50%
Lincoln National Life Insurance Company	15	4	0	0%	0%

Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overturned/ Modified
Lincoln National Life Insurance Company, The*	90	26	0	0%	0%
MAMSI Life and Health Insurance Company	1,216	0	95	51%	49%
Metropolitan Life Insurance Company	306	100	23	61%	39%
Mutual of Omaha Insurance Company	43	0	1	0%	100%
Optimum Choice, Inc.*	3,105	0	2,783	29%	71%
Principal Life Insurance Company	1,329	0	75	87%	13%
Reliance Standard Life Insurance Company	96	0	28	61%	39%
Standard Insurance Company	431	0	82	62%	38%
Starmount Life Insurance Company	264	0	0	0%	0%
Sun Life Assurance Company of Canada	564	4	31	48%	52%
United Concordia Insurance Company	461	0	162	44%	56%
United of Omaha Life Insurance Company	426	15	2	50%	50%
United States Fire Insurance Company*	10	0	1	100%	0%
UnitedHealthcare Insurance Company	17,400	0	1,389	43%	57%
UnitedHealthcare of the Mid-Atlantic, Inc.	528	0	64	52%	48%
Wellfleet Group LLC	470	0	75	41%	59%
Wellfleet Insurance Company	14	0	3	33%	67%
Wellpoint Maryland, Inc.	104	4	1	100%	0%
Totals	117,519	218	13,221	44%	56%

* Indicates possible, but not verified, anomalies in the data reporting.

**Carrier Cases
Denial Rate of Clean Claims**

Carrier	Total Enrolled (Avg)	Total Clean Claims	Total Adverse Decisions	Denial Rate
Aetna Dental Inc.	1,063	5,246	611	11.65%
Aetna Health Inc. (a Pennsylvania corporation)	5,442	117,933	928	0.79%
Aetna Life Insurance Company	11,146	172,039	979	0.57%
Ameritas Life Insurance Corp.	35,400	11,993	836	6.97%
CareFirst BlueChoice, Inc.*	412,986	9,620,254	31,988	0.33%
Carefirst of Maryland, Inc.	33,246	906,331	12,930	1.43%
CIGNA Health and Life Insurance Company	163,129	642,810	26,033	4.05%
Colonial Life & Accident Insurance Company	1,429	1,309	67	5.12%
Delta Dental Insurance Company*	17,172	36,085	14	0.04%
Delta Dental of Pennsylvania	153,510	290,039	59	0.02%
Dental Network, Inc.*	0	0	2	N/A
Dentegra Insurance Company*	17,708	15,214	14	0.09%
Dominion Dental Services, Inc.	9,139	34,938	2,180	6.24%
Golden Rule Insurance Company	14,122	14,685	23	0.16%
Group Hospitalization and Medical Services, Inc.	29,192	829,667	10,622	1.28%
Guardian Life Insurance Company of America	40,537	142,718	1,244	0.87%
Independence American Insurance Company	438	0	0	0.00%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	184,394	2,390,602	2,107	0.09%
Kaiser Permanente Insurance Company*	5,862	6,836	10	0.15%
Lincoln National Life Insurance Company	0	0	15	N/A

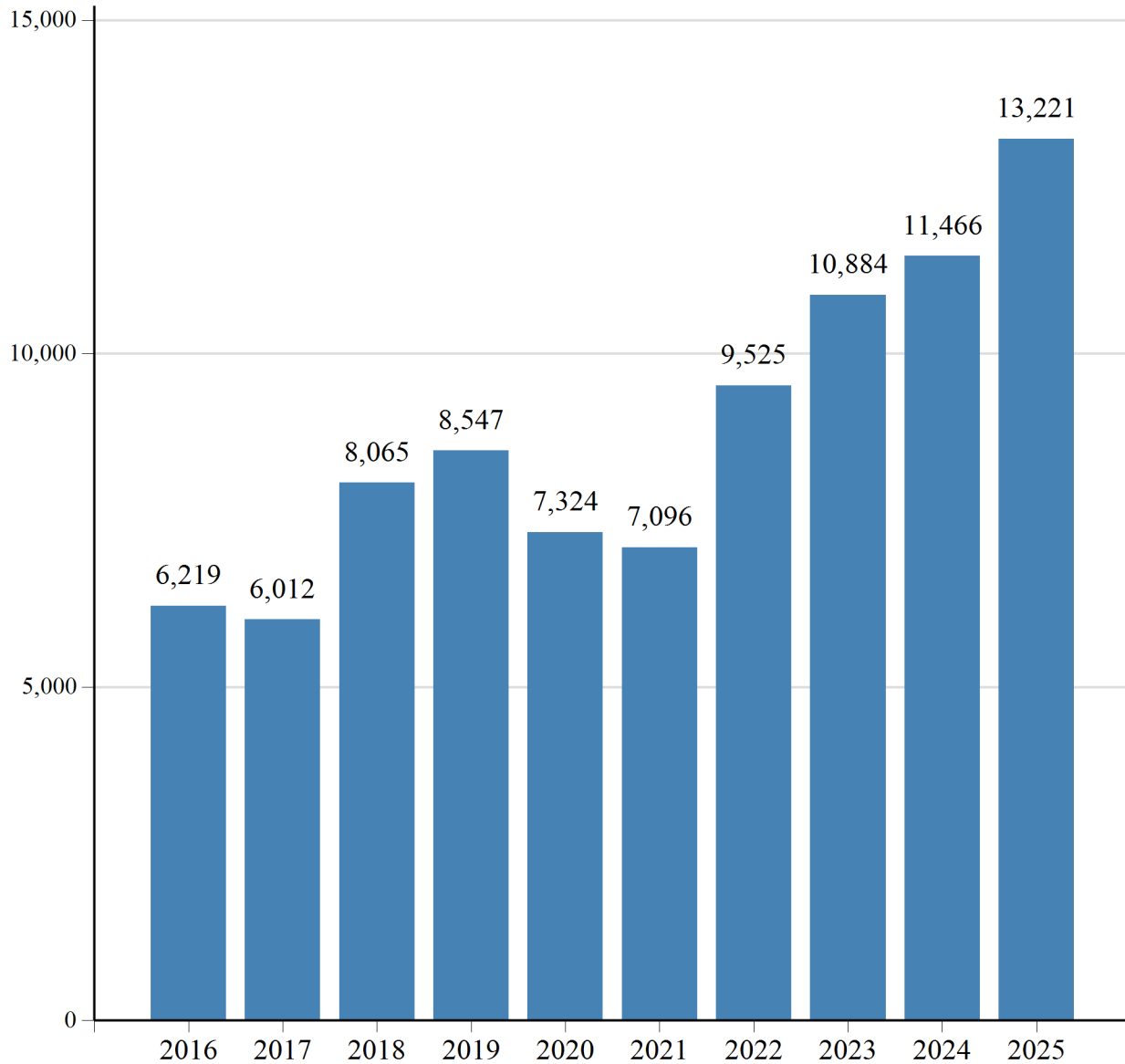
Carrier	Total Enrolled (Avg)	Total Clean Claims	Total Adverse Decisions	Denial Rate
Lincoln National Life Insurance Company, The*	0	0	90	N/A
MAMSI Life and Health Insurance Company	16,979	363,310	1,216	0.33%
Metropolitan Life Insurance Company	0	0	306	N/A
Mutual of Omaha Insurance Company	4,871	4,257	43	1.01%
Optimum Choice, Inc.	259,412	587,969	3,105	0.53%
Principal Life Insurance Company	23,698	111,923	1,329	1.19%
Reliance Standard Life Insurance Company	481	917	96	10.47%
Standard Insurance Company	2,647	6,764	431	6.37%
Starmount Life Insurance Company	10,213	7,767	264	3.40%
Sun Life Assurance Company of Canada	0	0	564	N/A
United Concordia Insurance Company	183,380	44,935	461	1.03%
United of Omaha Life Insurance Company	4,314	5,113	426	8.33%
United States Fire Insurance Company*	0	1,405	10	0.71%
UnitedHealthcare Insurance Company	303,635	2,055,561	17,400	0.85%
UnitedHealthcare of the Mid-Atlantic, Inc.	13,702	88,843	528	0.59%
Wellfleet Group LLC	16,498	190,424	470	0.25%
Wellfleet Insurance Company	216	1,708	14	0.82%
Wellpoint Maryland, Inc.	1,119	6,839	104	1.52%

- The denial rate reflects medical necessity denials in relation to clean claims, which excludes coverage denials, and denials for administrative issues, coding errors, paperwork problems and other non-specified reasons.
- The denial rate is calculated in this table as a percentage of the clean claims denied based on medical necessity.

* Indicates possible, but not verified, anomalies in the data reporting.

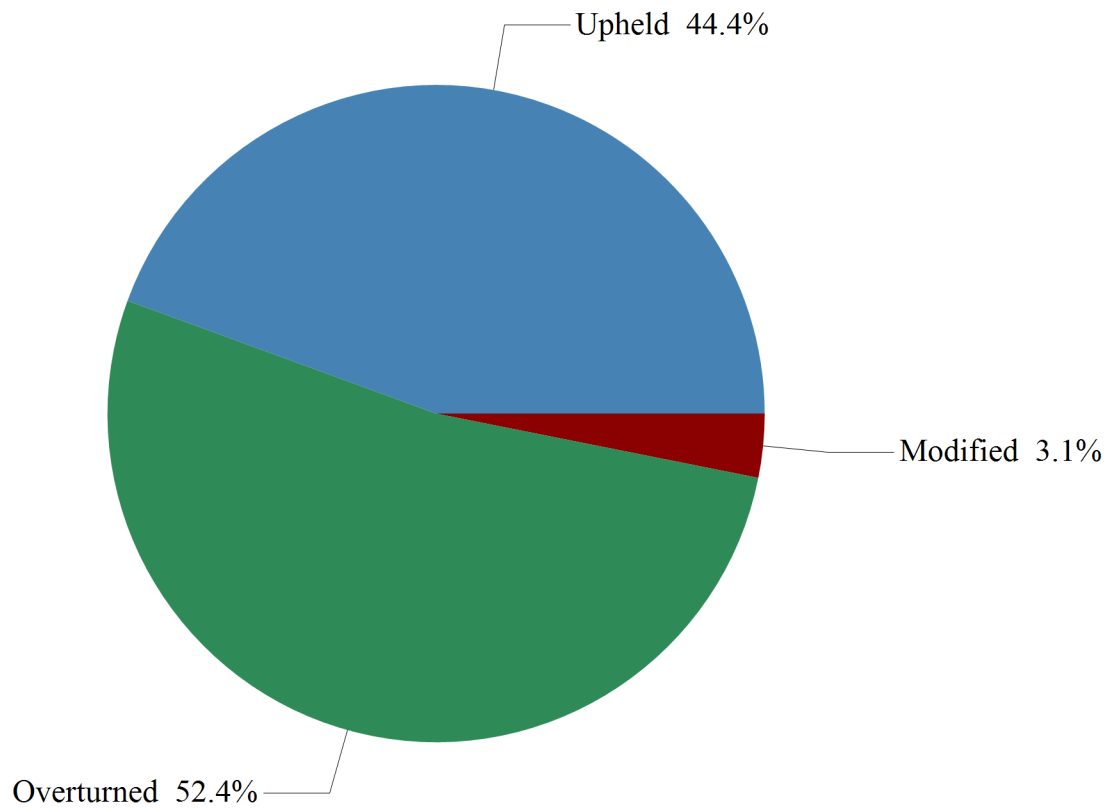
Carrier Grievances Cases Number of Grievances Over 10 Fiscal Years

The chart below shows the history of the number of grievances filed with carriers under the Appeals and Grievances Law over the last 10 fiscal years.



Carrier Grievances Cases Outcomes

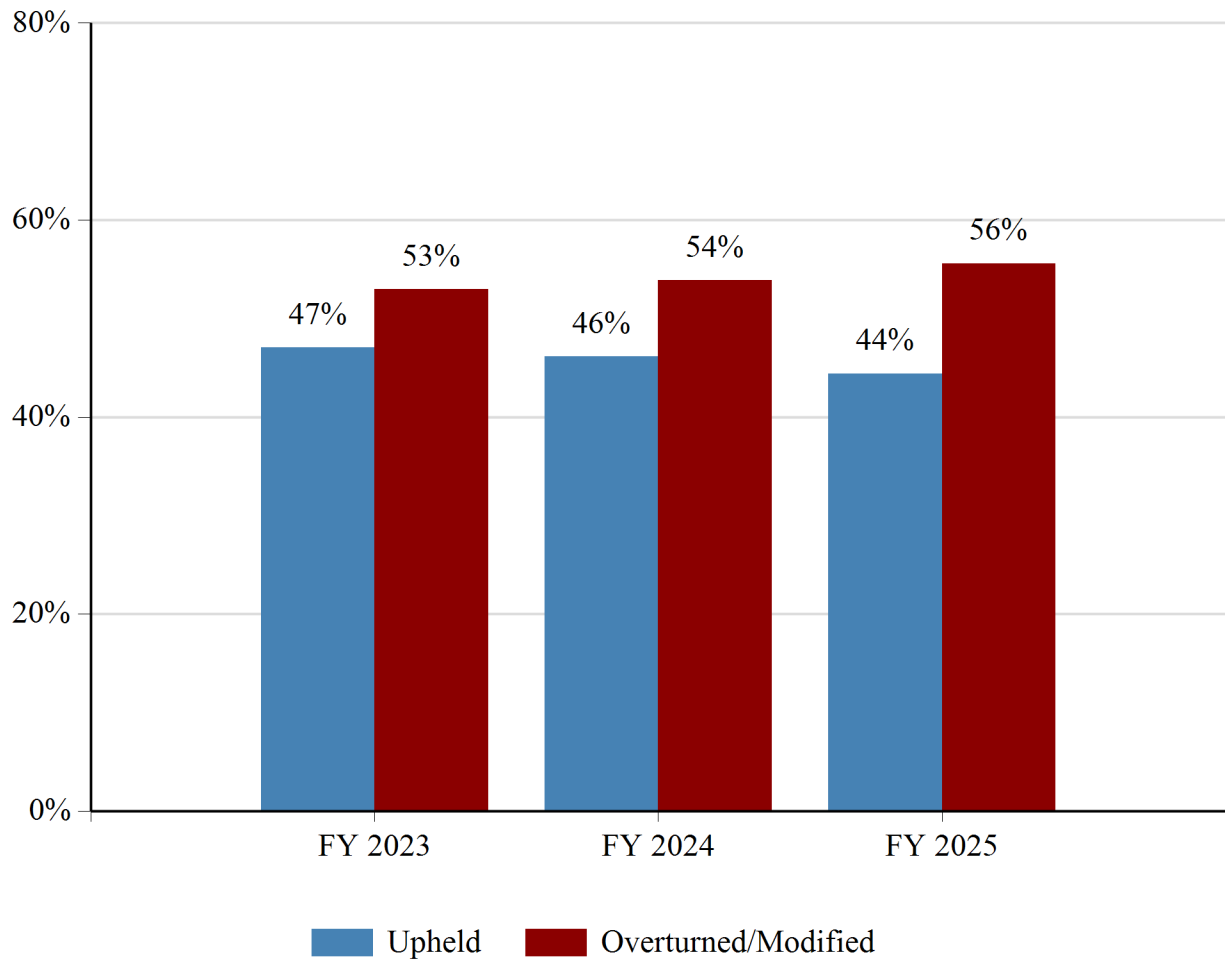
The chart below describes the outcomes of the 13,221 internal grievances filed with carriers in FY 2025, as reported by the carriers.



Percentages may not equal 100% due to rounding.

Carrier Grievances Cases Three Year Comparison of Outcomes

The chart below compares the year-to-year outcomes of grievances filed with carriers, as reported by the carriers.



Carrier Grievances Cases Types of Services

Carriers must report the types of services involved in the adverse decisions they issue and the internal grievances they receive. The table below details the types of services involved in the adverse decisions issued and internal grievances filed in FY 2025, as reported by carriers.

Type of Service	Adverse Decisions		Grievances	
Dental	16,580	14.108%	1,995	15.090%
Durable Medical Equipment	1,390	1.183%	355	2.685%
Emergency Room	62	0.053%	46	0.348%
Home Health	114	0.097%	3	0.023%
Inpatient Hospital	2,182	1.857%	257	1.944%
Laboratory, Radiology	22,634	19.260%	2,194	16.595%
Mental Health / Substance Abuse	1,676	1.426%	224	1.694%
Other*	1,502	1.278%	1,817	13.743%
Pharmacy	61,960	52.723%	5,090	38.499%
Physician	4,756	4.047%	1,101	8.328%
PT, OT, ST, including inpatient rehabilitation	4,441	3.779%	111	0.840%
Skilled Nursing Facility, Sub Acute Facility, Nursing Home	222	0.189%	28	0.212%
Totals	117,519	100%	13,221	100%

*"Other" means obesity, IVF, podiatry, hearing and vision.

Carrier Grievances Cases Outcomes by Service Type

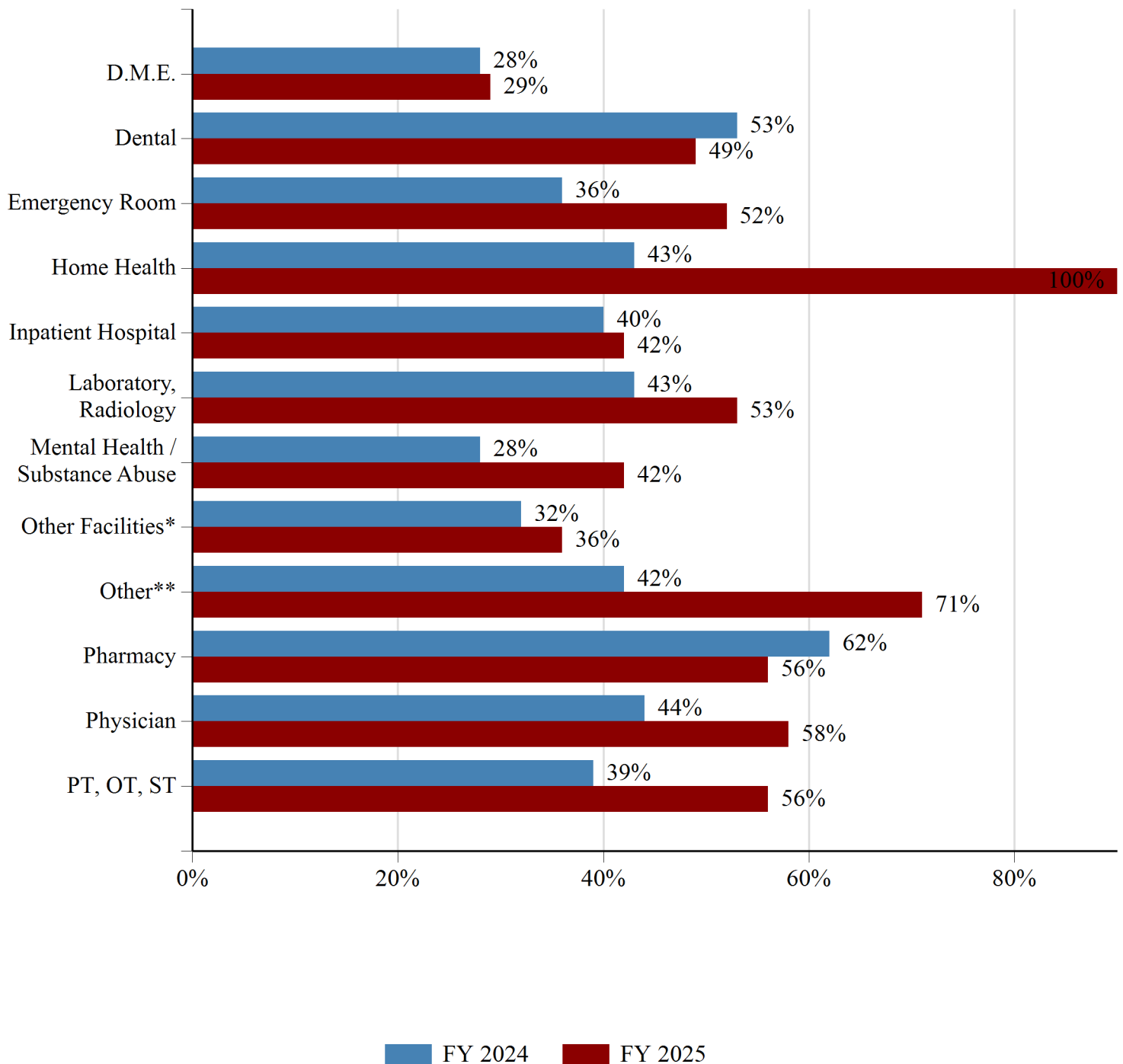
Carriers must identify the types of services involved in the internal grievances they receive and the outcomes of those grievances. The table below compares the variance in the outcomes of grievances based upon the types of services being disputed. The table below is based upon carrier reported data. Overturned or modified cases have been combined to more clearly present the data.

Type of Service	Total Grievances	Upheld	Overtured/ Modified
Dental	1,995	51%	49%
Durable Medical Equipment	355	71%	29%
Emergency Room	46	48%	52%
Home Health	3	0%	100%
Inpatient Hospital	257	58%	42%
Laboratory, Radiology	2,194	47%	53%
Mental Health / Substance Abuse	224	58%	42%
Other*	1,817	29%	71%
Pharmacy	5,090	44%	56%
Physician	1,101	42%	58%
PT, OT, ST, including inpatient rehabilitation	111	44%	56%
Skilled Nursing Facility, Sub Acute Facility, Nursing Home	28	64%	36%
Totals	13,221	44%	56%

*"Other" means obesity, IVF, podiatry, hearing and vision.

Carrier Grievances Cases Two Year Comparison by Service Type

The chart below compares the percentages of grievances carriers overturned or modified by types of services, comparing FY 2024 and FY 2025.



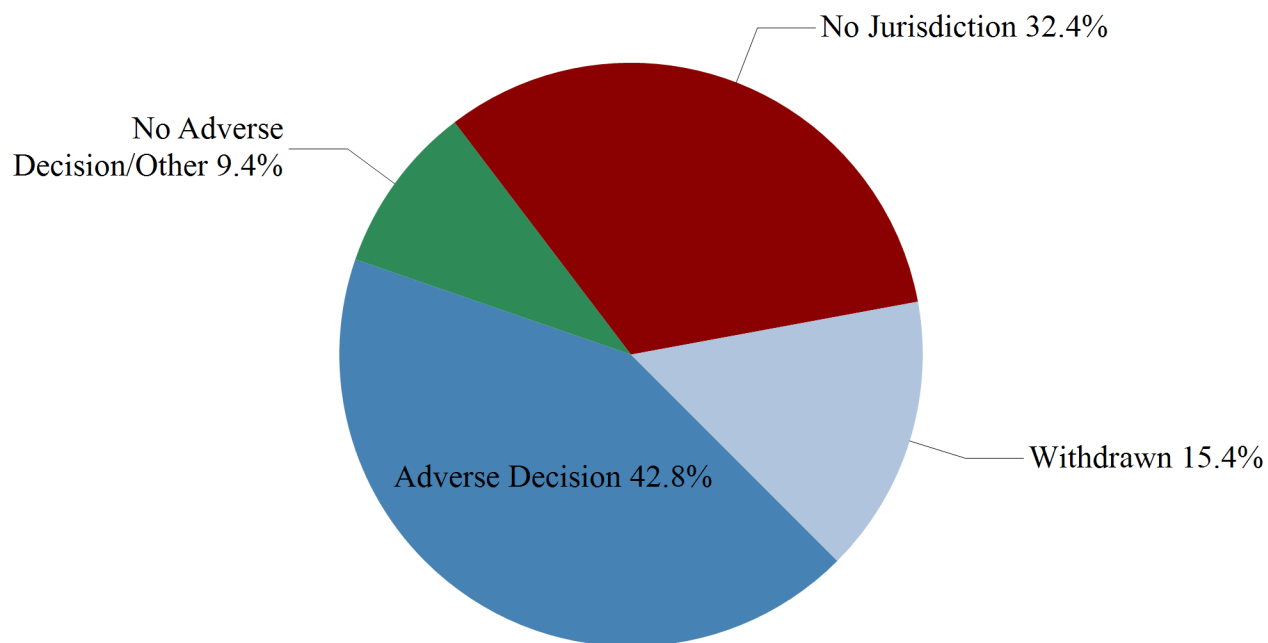
* "Other Facilities" means Skilled Nursing, Sub Acute and Nursing Homes.

** "Other" means obesity, IVF, podiatry, hearing and vision.

MIA Appeals and Grievances Complaints Initial Review of Cases

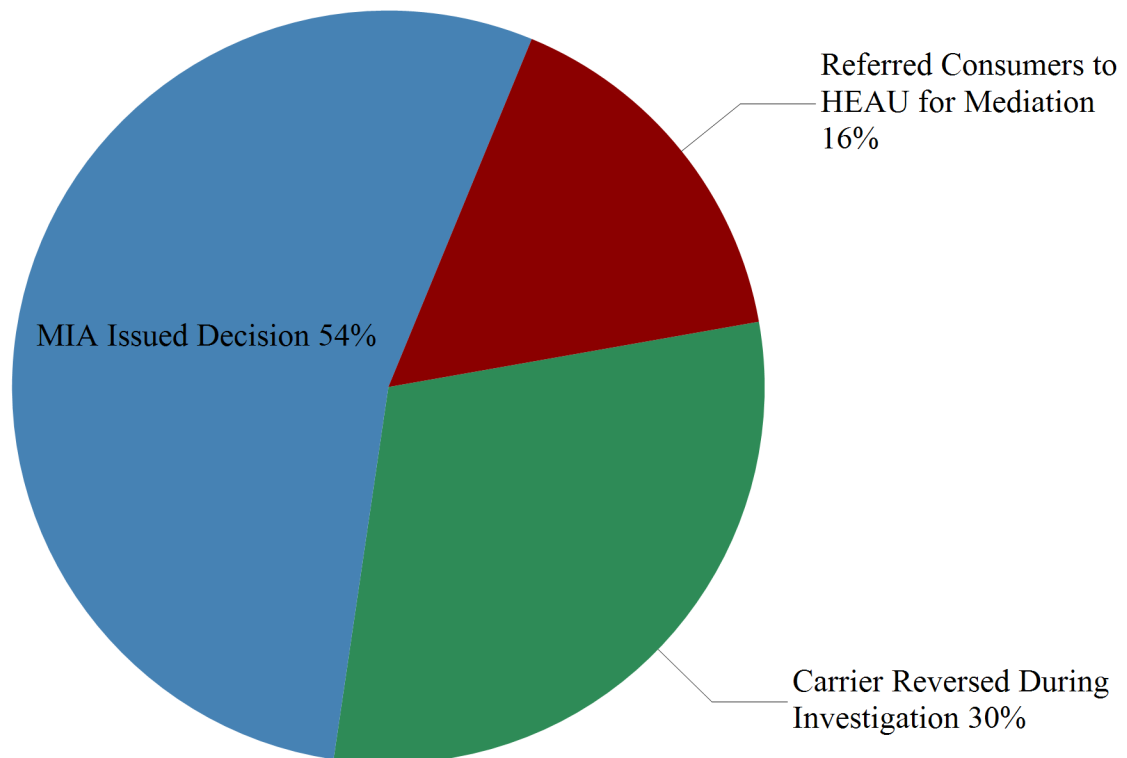
The MIA Appeals and Grievances Unit does not handle all of the complaints it receives. The Unit reviews each complaint to determine if the carrier is subject to State jurisdiction, if the complaint involves an adverse decision, and if the internal grievance process has been exhausted. Moreover, some complaints to the MIA are withdrawn or there is not enough information to complete the review.

The chart below details the initial disposition of the 1110 cases filed with the MIA's Appeals and Grievances Unit during FY 2025.



MIA Appeals and Grievances Complaints Initial Disposition of Grievances

During FY 2025, the MIA determined that 475 complaints challenged carrier adverse decisions that were subject to state jurisdiction. The MIA referred 76 consumers to the HEAU where the patient had not exhausted the carrier's internal grievance process. The remaining cases resulted in the carriers reversing their decisions or the MIA issuing a decision. The chart below details the initial disposition of the 475 grievances the MIA reviewed during FY 2025.



MIA Appeals and Grievances Cases Carriers and Disposition

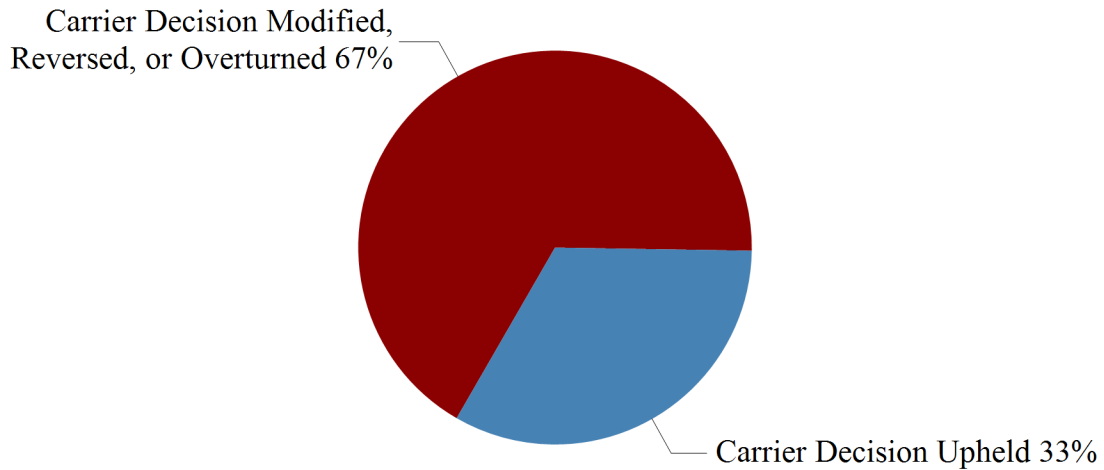
The table below details the outcomes of the 399 grievances complaints the MIA investigated during FY 2025. The data, as reported by the MIA, does not include "coverage decisions" (contractual exclusions).

Carrier	Total Grievance Complaints	MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Aetna Health Inc. (a Pennsylvania corporation)	3	1	33.3%	0	0.0%	0	0.0%	2	66.7%
Aetna Health Insurance Company	4	1	25.0%	1	25.0%	1	25.0%	1	25.0%
Aetna Life Insurance Company	4	2	50.0%	1	25.0%	0	0.0%	1	25.0%
Ameritas Life Insurance Corp.	4	1	25.0%	0	0.0%	1	25.0%	2	50.0%
CareFirst BlueChoice, Inc.	109	32	29.4%	28	25.7%	0	0.0%	49	45.0%
Carefirst of Maryland, Inc.	78	31	39.7%	25	32.1%	2	2.6%	20	25.6%
CIGNA Health and Life Insurance Company	17	13	76.5%	3	17.6%	0	0.0%	1	5.9%
Delta Dental Insurance Company	1	1	100.0%	0	0.0%	0	0.0%	0	0.0%
Dominion Dental Services, Inc.	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
Group Hospitalization and Medical Services, Inc.	16	4	25.0%	4	25.0%	1	6.3%	7	43.8%
Guardian Life Insurance Company of America	6	4	66.7%	0	0.0%	0	0.0%	2	33.3%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	16	4	25.0%	4	25.0%	2	12.5%	6	37.5%
MAMSI Life and Health Insurance Company	2	1	50.0%	0	0.0%	0	0.0%	1	50.0%
MedImpact Healthcare Systems, Inc.	48	10	20.8%	20	41.7%	0	0.0%	18	37.5%
Metropolitan Life Insurance Company	4	0	0.0%	0	0.0%	0	0.0%	4	100.0%
Optimum Choice, Inc.	7	3	42.9%	2	28.6%	0	0.0%	2	28.6%

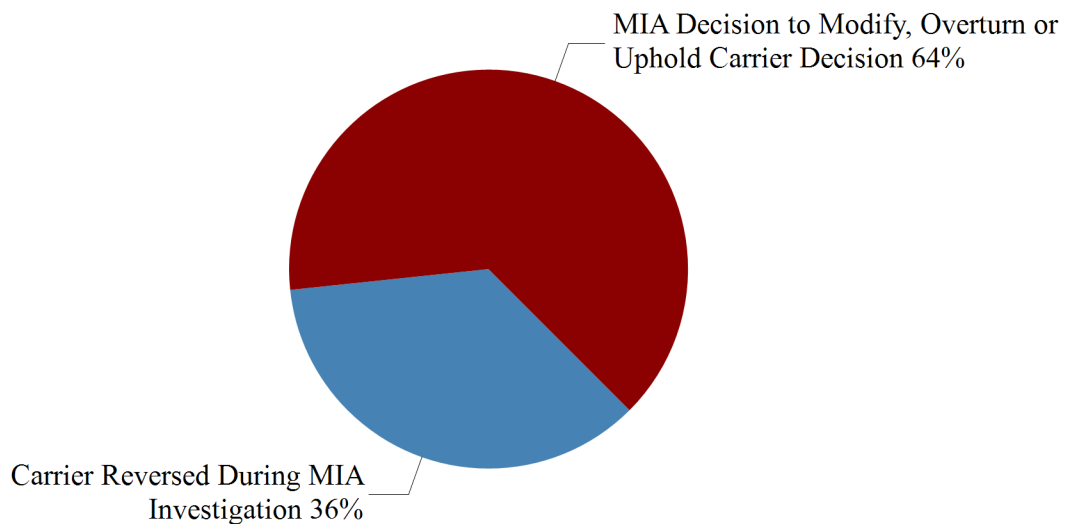
Carrier	Total Grievance Complaints	MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Principal Life Insurance Company	2	1	50.0%	0	0.0%	0	0.0%	1	50.0%
Sun Life Assurance Company of Canada	1	1	100.0%	0	0.0%	0	0.0%	0	0.0%
United Concordia Insurance Company	3	2	66.7%	0	0.0%	0	0.0%	1	33.3%
United Concordia Life and Health Insurance Company	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
UnitedHealthcare Insurance Company	71	20	28.2%	23	32.4%	5	7.0%	23	32.4%
UnitedHealthcare of the Mid-Atlantic, Inc.	1	0	0.0%	0	0.0%	1	100.0%	0	0.0%
Totals	399	132	33%	111	28%	13	3%	143	36%

MIA Appeals and Grievances Cases Disposition Following Investigation

The chart below reflects the overall outcomes of the 399 grievances the MIA investigated during FY 2025.

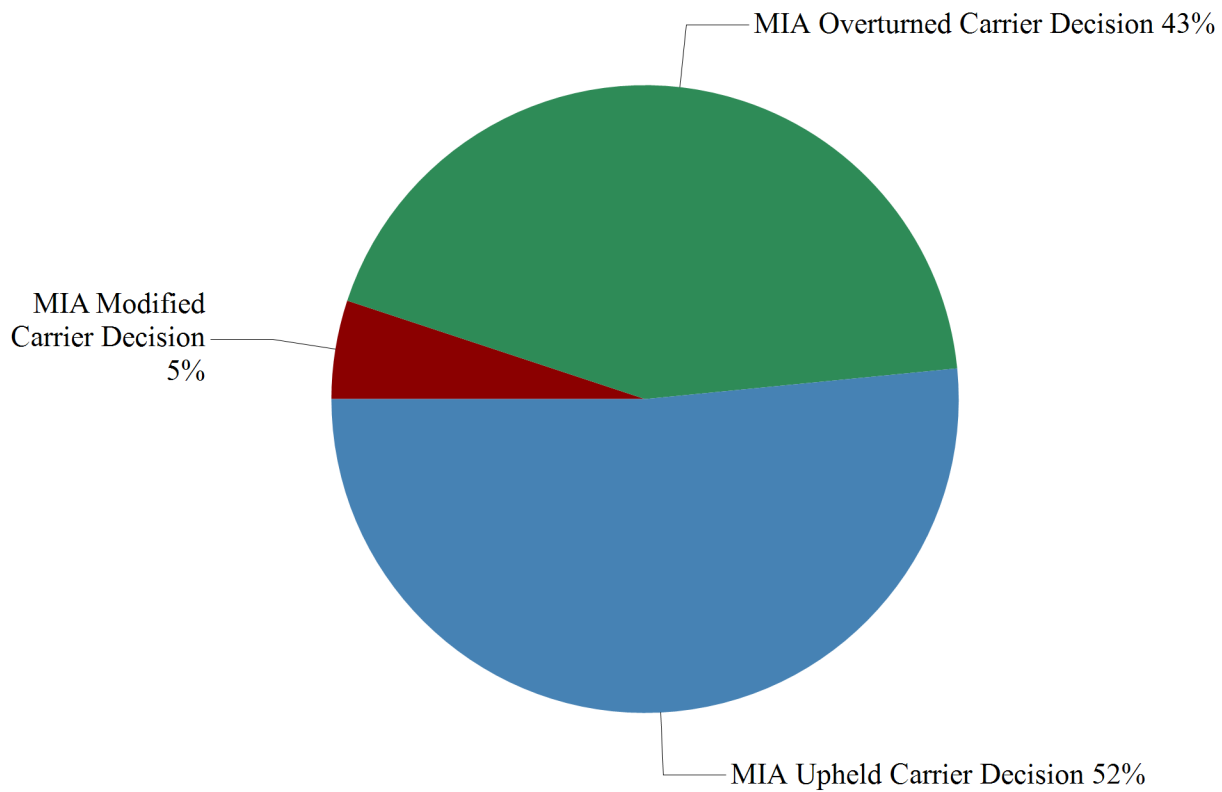


The chart below reflects the percentages of cases reversed by the carrier during the investigative process and those cases that resulted in an MIA decision.



MIA Appeals and Grievances Cases Disposition Resulting from IRO Review

The chart below describes the outcomes of the 256 cases the MIA forwarded to an IRO for review in FY 2025.



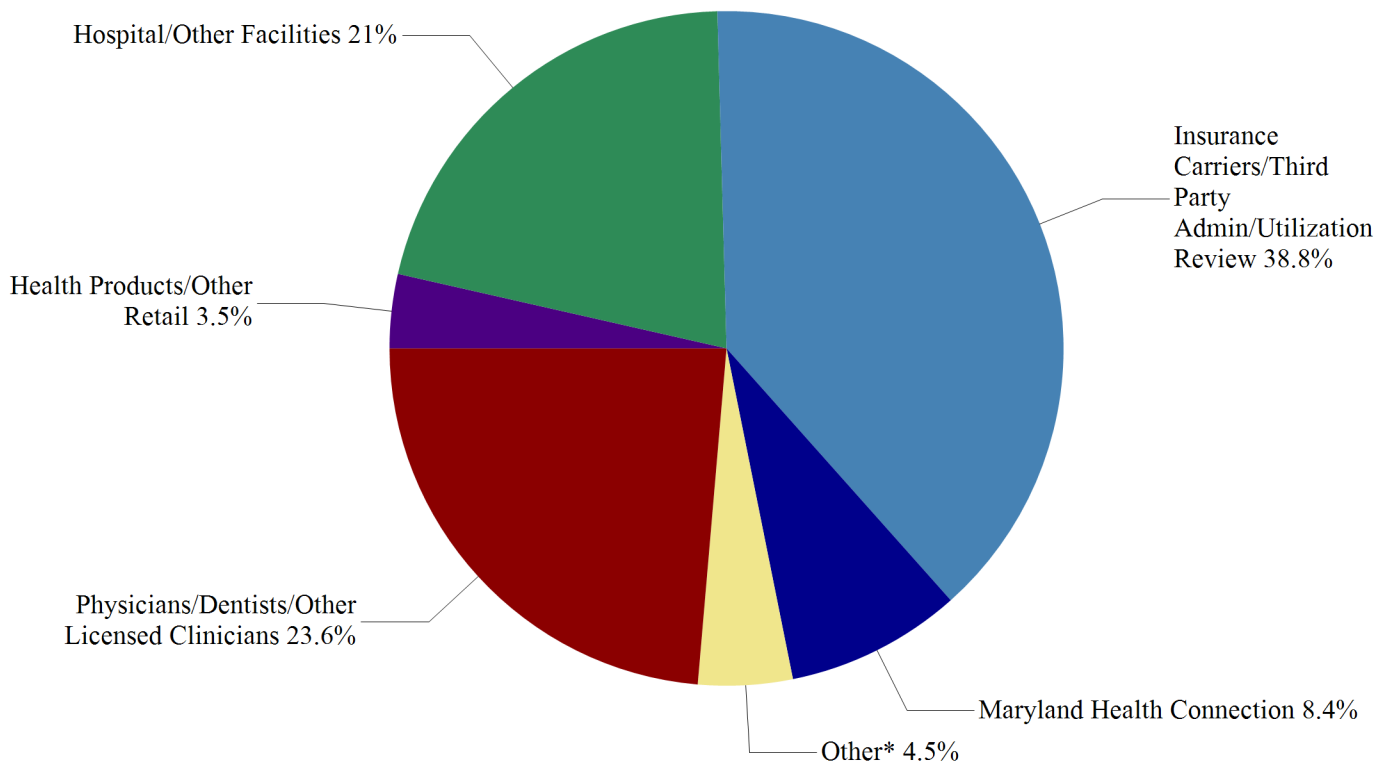
MIA Appeals and Grievances Cases Types of Services Denied and Outcomes

The table below identifies the types of services involved in grievances the MIA investigated during FY 2025. It shows how the outcome varies based on the types of services involved in the grievances. The National Association of Insurance Commissioners defines the types of services identified below.

Type Of Service	Total Grievance Complaints		MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Air Ambulance	3	<1 %	3	100%	0	0%	0	0%	0	0%
Ambulatory Patient Services	1	<1 %	0	0%	0	0%	0	0%	1	100%
Cosmetic	4	1%	2	50%	0	0%	0	0%	2	50%
Denial of Hospital Days	1	<1 %	0	0%	1	100%	0	0%	0	0%
Dental Care Services	40	10%	15	38%	0	0%	2	5%	23	58%
Durable Medical Equipment	10	3%	3	30%	4	40%	1	10%	2	20%
Experimental	9	2%	6	67%	2	22%	0	0%	1	11%
Genetic Testing	1	<1 %	0	0%	1	100%	0	0%	0	0%
In-Patient Rehabilitation Services	1	<1 %	1	100%	0	0%	0	0%	0	0%
Lab, Imaging, Test Services	64	16%	26	41%	26	41%	0	0%	12	19%
Mental Health/Substance Abuse (Inpatient) Services	4	1%	3	75%	1	25%	0	0%	0	0%
Mental Health/Substance Abuse (Outpatient) Services	7	2%	0	0%	2	29%	2	29%	3	43%
Outpatient Services	3	<1 %	0	0%	2	67%	0	0%	1	33%
Pharmacy Services/Formulary Issues	185	46%	54	29%	53	29%	0	0%	78	42%
Physician Services	59	15%	19	32%	14	24%	8	14%	18	31%
PT, OT, ST Services	4	1%	0	0%	3	75%	0	0%	1	25%
Rehabilitative/habilitative Care	1	<1 %	0	0%	1	100%	0	0%	0	0%
Skilled Nursing Facility Care Services	2	<1 %	0	0%	1	50%	0	0%	1	50%
Totals	399	100.0%	132	33.1%	111	27.8%	13	3.3%	143	35.8%

HEAU Cases Subject of Complaints

The HEAU mediates a number of different types of patient disputes with health care providers and health insurance carriers. Most complaints involve provider billing or insurance coverage issues, but HEAU cases also involve access to medical records, sales and service problems with health care products, and various other issues encountered in the health care marketplace. In addition, the HEAU assists consumers who experience enrollment difficulties on Maryland Health Connection. The chart below illustrates the types of industries involved in the cases the HEAU closed during FY 2025. The HEAU closed 2,068 complaints. Some complaints were filed against more than one industry.

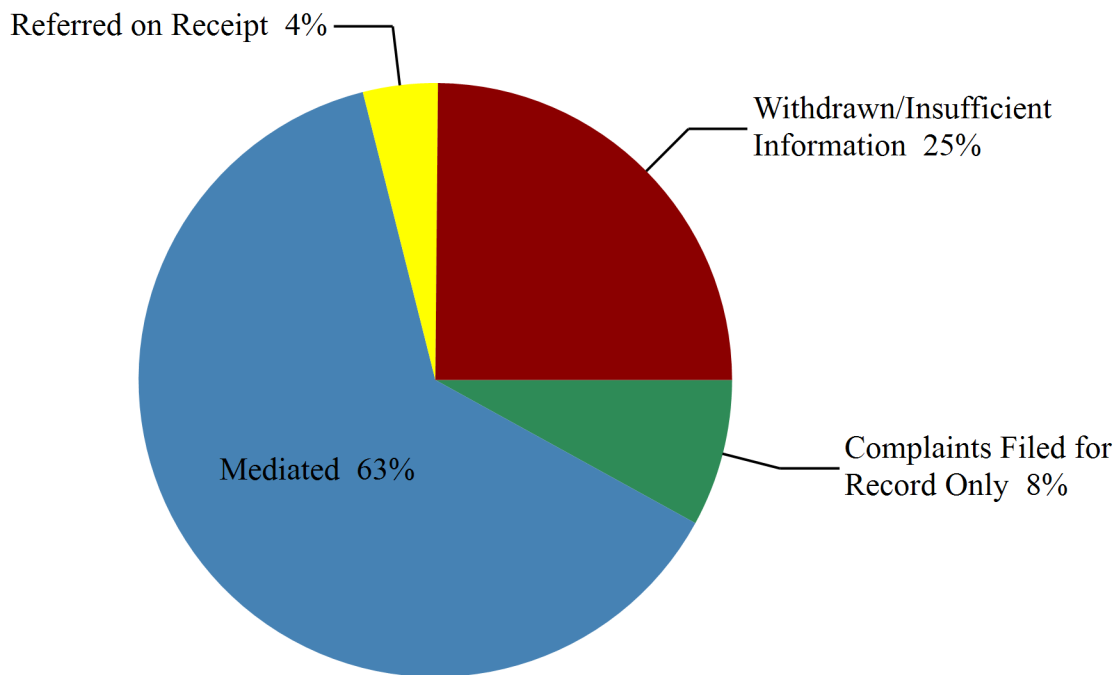


* "Other" includes Ambulance, Collection/Billing Entities, Broker, Government Agency, Employer, Medical Mgmt Services Organization, Online Marketing and other non-specific categories (e.g. HSA/FSA).

Percentages may not equal 100% due to rounding.

HEAU Appeals and Grievances Cases Initial Disposition

The HEAU does not mediate all of the Appeals and Grievances complaints filed. Some consumers, or other persons, file complaints but never complete an authorization to release medical records, a form required by the HEAU to mediate the case. Other complaints are filed for the record only or are referred to another more appropriate agency. The chart below details the initial disposition of the 712 Appeals and Grievances cases closed by the HEAU during FY 2025.



HEAU Mediated Appeals and Grievances Cases Carriers, Regulatory Authority and Disposition

The table below identifies the names of the carriers and the outcomes of the Appeals and Grievances cases mediated and closed by the HEAU during FY 2025. “Carriers” are defined in this report to include insurers, nonprofit health service plans, HMOs, dental plans, third-party administrators, utilization review agents, pharmaceutical benefit management companies, and any other entity that provides health benefit plans or adjudicates claims. Some complaints involved more than one carrier; the HEAU mediated and closed 449 cases in FY 2025. Maryland Health Connection is listed as a carrier in cases where the appeal or grievance involved a dispute that required both the carrier and Maryland Health Connection to act to resolve the dispute.

Carrier	Total Cases	Upheld	Overtaken/Modified
Administrative Concepts, Inc.			
Not State Regulated	2	1	50%
Total Complaints	2	1	50%
Aetna Health Inc.			
State Regulated	5	3	60%
Not State Regulated	26	11	42%
Total Complaints	31	14	45%
AFLAC Insurance			
State Regulated	1	0	0%
Total Complaints	1	0	0%
Allegiance Benefit Plan Management, Inc.			
Not State Regulated	3	1	33%
Total Complaints	3	1	33%
Allied Benefit Systems, LLC			
Not State Regulated	1	0	0%
Total Complaints	1	0	0%
American Plan Administrators			
Not State Regulated	1	1	100%
Total Complaints	1	1	100%
Ameritas Life Insurance Corp.			
Not State Regulated	1	1	100%
Total Complaints	1	1	100%

Carrier	Total Cases	Upheld		Overturned/Modified	
Anthem Blue Cross and Blue Shield					
State Regulated	1	0	0%	1	100%
Not State Regulated	5	4	80%	1	20%
Total Complaints	6	4	67%	2	33%
Anthem Blue Cross of California					
Not State Regulated	1	0	0%	1	100%
Total Complaints	1	0	0%	1	100%
Anthem BlueCross BlueShield of Georgia					
Not State Regulated	1	1	100%	0	0%
Total Complaints	1	1	100%	0	0%
Anthem UM Services, Inc.					
Not State Regulated	1	0	0%	1	100%
Total Complaints	1	0	0%	1	100%
Blue Cross Blue Shield of Illinois					
Not State Regulated	2	2	100%	0	0%
Total Complaints	2	2	100%	0	0%
BlueCross and BlueShield of Minnesota					
Not State Regulated	1	0	0%	1	100%
Total Complaints	1	0	0%	1	100%
BlueCross BlueShield of Texas					
Not State Regulated	1	1	100%	0	0%
Total Complaints	1	1	100%	0	0%
CareFirst					
State Regulated	68	24	35%	44	65%
Not State Regulated	75	39	52%	36	48%
Total Complaints	143	63	44%	80	56%
CareFirst Administrators					
Not State Regulated	9	6	67%	3	33%
Total Complaints	9	6	67%	3	33%

Carrier	Total Cases	Upheld		Overturned/Modified	
CareFirst FEP Dental					
Not State Regulated	1	1	100%	0	0%
Total Complaints	1	1	100%	0	0%
CareFirst the Dental Network					
State Regulated	5	5	100%	0	0%
Not State Regulated	1	0	0%	1	100%
Total Complaints	6	5	83%	1	17%
Carelon Medical Benefits Management, Inc.					
State Regulated	1	0	0%	1	100%
Not State Regulated	3	3	100%	0	0%
Total Complaints	4	3	75%	1	25%
CIGNA					
State Regulated	4	2	50%	2	50%
Not State Regulated	36	23	64%	13	36%
Total Complaints	40	25	63%	15	38%
Cigna Dental					
Not State Regulated	4	1	25%	3	75%
Total Complaints	4	1	25%	3	75%
CVS Caremark					
State Regulated	4	3	75%	1	25%
Not State Regulated	15	5	33%	10	67%
Total Complaints	19	8	42%	11	58%
Davis Vision, Inc.					
State Regulated	1	0	0%	1	100%
Not State Regulated	1	0	0%	1	100%
Total Complaints	2	0	0%	2	100%
Delta Dental					
State Regulated	6	4	67%	2	33%
Not State Regulated	5	2	40%	3	60%
Total Complaints	11	6	55%	5	45%

Carrier	Total Cases	Upheld		Overturned/Modified	
Dominion National					
State Regulated	2	2	100%	0	0%
Not State Regulated	2	0	0%	2	100%
Total Complaints	4	2	50%	2	50%
EviCore Healthcare					
State Regulated	1	0	0%	1	100%
Not State Regulated	3	0	0%	3	100%
Total Complaints	4	0	0%	4	100%
Express Scripts					
Not State Regulated	3	2	67%	1	33%
Total Complaints	3	2	67%	1	33%
Federal Life Insurance Company					
State Regulated	1	1	100%	0	0%
Total Complaints	1	1	100%	0	0%
Freedom Life Insurance Company of America					
State Regulated	3	3	100%	0	0%
Total Complaints	3	3	100%	0	0%
Government Employees Health Association (GEHA)					
Not State Regulated	4	3	75%	1	25%
Total Complaints	4	3	75%	1	25%
Guardian Life Insurance Company of America					
State Regulated	1	1	100%	0	0%
Not State Regulated	1	1	100%	0	0%
Total Complaints	2	2	100%	0	0%
Health Insurance Solutions, Inc.					
Not State Regulated	1	1	100%	0	0%
Total Complaints	1	1	100%	0	0%
Highmark					
Not State Regulated	3	1	33%	2	67%
Total Complaints	3	1	33%	2	67%

Carrier	Total Cases	Upheld		Overturned/Modified	
Horizon Blue Cross Blue Shield of New Jersey					
Not State Regulated	2	1	50%	1	50%
Total Complaints	2	1	50%	1	50%
Humana					
Not State Regulated	1	1	100%	0	0%
Total Complaints	1	1	100%	0	0%
Humana Military/Tricare					
Not State Regulated	2	2	100%	0	0%
Total Complaints	2	2	100%	0	0%
IMG (International Medical Group)					
Not State Regulated	1	0	0%	1	100%
Total Complaints	1	0	0%	1	100%
Independence Blue Cross Blue Shield					
Not State Regulated	1	0	0%	1	100%
Total Complaints	1	0	0%	1	100%
ISO International Student Insurance					
Not State Regulated	1	1	100%	0	0%
Total Complaints	1	1	100%	0	0%
Johns Hopkins Advantage MD					
Not State Regulated	3	2	67%	1	33%
Total Complaints	3	2	67%	1	33%
Johns Hopkins HealthCare LLC					
Not State Regulated	1	0	0%	1	100%
Total Complaints	1	0	0%	1	100%
Johns Hopkins US Family Health Plan					
Not State Regulated	2	2	100%	0	0%
Total Complaints	2	2	100%	0	0%

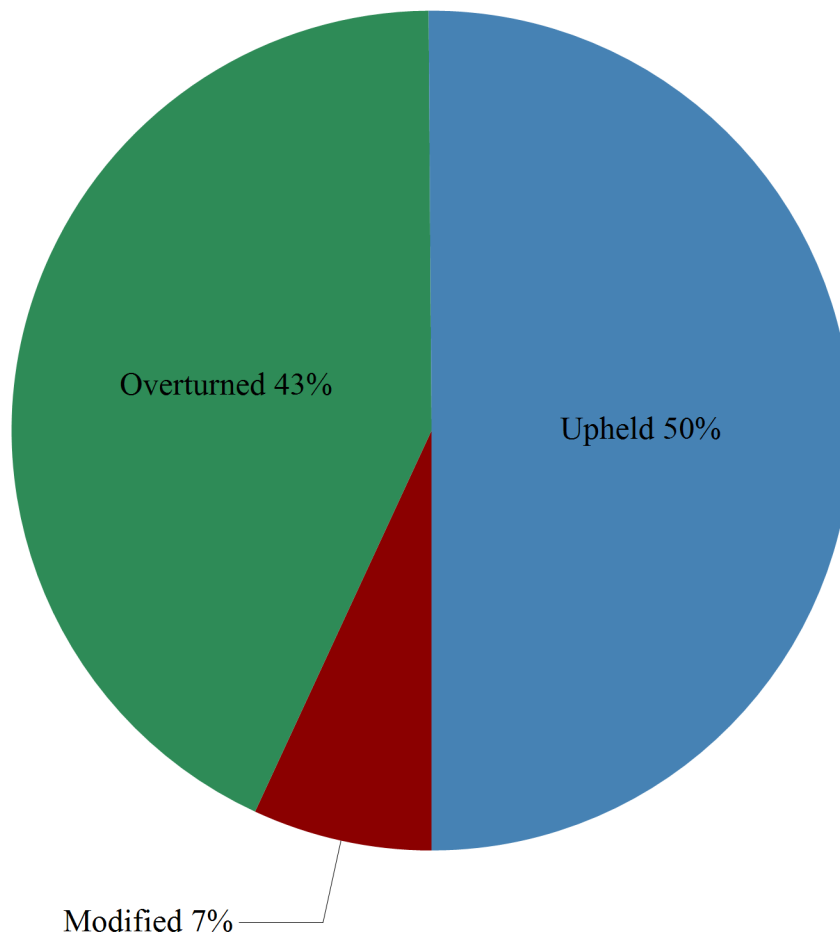
Carrier	Total Cases	Upheld		Overturned/Modified	
Kaiser Permanente of the Mid Atlantic States					
State Regulated	16	8	50%	8	50%
Not State Regulated	7	5	71%	2	29%
Total Complaints	23	13	57%	10	43%
Luminare Health					
Not State Regulated	1	1	100%	0	0%
Total Complaints	1	1	100%	0	0%
Maryland Health Connection					
State Regulated	1	0	0%	1	100%
Total Complaints	1	0	0%	1	100%
MedImpact Healthcare Systems					
State Regulated	2	2	100%	0	0%
Not State Regulated	4	1	25%	3	75%
Total Complaints	6	3	50%	3	50%
Meritain Health					
Not State Regulated	1	1	100%	0	0%
Total Complaints	1	1	100%	0	0%
Metropolitan Life Insurance Company					
State Regulated	1	0	0%	1	100%
Not State Regulated	5	3	60%	2	40%
Total Complaints	6	3	50%	3	50%
Northeast Delta Dental					
Not State Regulated	1	0	0%	1	100%
Total Complaints	1	0	0%	1	100%
Optum					
State Regulated	1	0	0%	1	100%
Total Complaints	1	0	0%	1	100%
Optum Rx					
State Regulated	1	0	0%	1	100%
Not State Regulated	1	1	100%	0	0%
Total Complaints	2	147	50%	1	50%

Carrier	Total Cases	Upheld		Overturned/Modified	
Quantum Health, Inc					
Not State Regulated	2	2	100%	0	0%
Total Complaints	2	2	100%	0	0%
Samba					
Not State Regulated	1	1	100%	0	0%
Total Complaints	1	1	100%	0	0%
Sheet Metal Workers Local 100 HW Fund					
Not State Regulated	1	0	0%	1	100%
Total Complaints	1	0	0%	1	100%
Texas BlueCross BlueShield					
Not State Regulated	2	1	50%	1	50%
Total Complaints	2	1	50%	1	50%
Tricare					
Not State Regulated	1	1	100%	0	0%
Total Complaints	1	1	100%	0	0%
UHC Global					
Not State Regulated	1	0	0%	1	100%
Total Complaints	1	0	0%	1	100%
UMR					
Not State Regulated	1	0	0%	1	100%
Total Complaints	1	0	0%	1	100%
United Behavioral Health					
Not State Regulated	1	0	0%	1	100%
Total Complaints	1	0	0%	1	100%
United Concordia Insurance Company					
Not State Regulated	3	2	67%	1	33%
Total Complaints	3	2	67%	1	33%

Carrier	Total Cases	Upheld		Overturned/Modified	
UnitedHealthcare					
State Regulated	50	26	52%	24	48%
Not State Regulated	46	14	30%	32	70%
Total Complaints	96	40	42%	56	58%

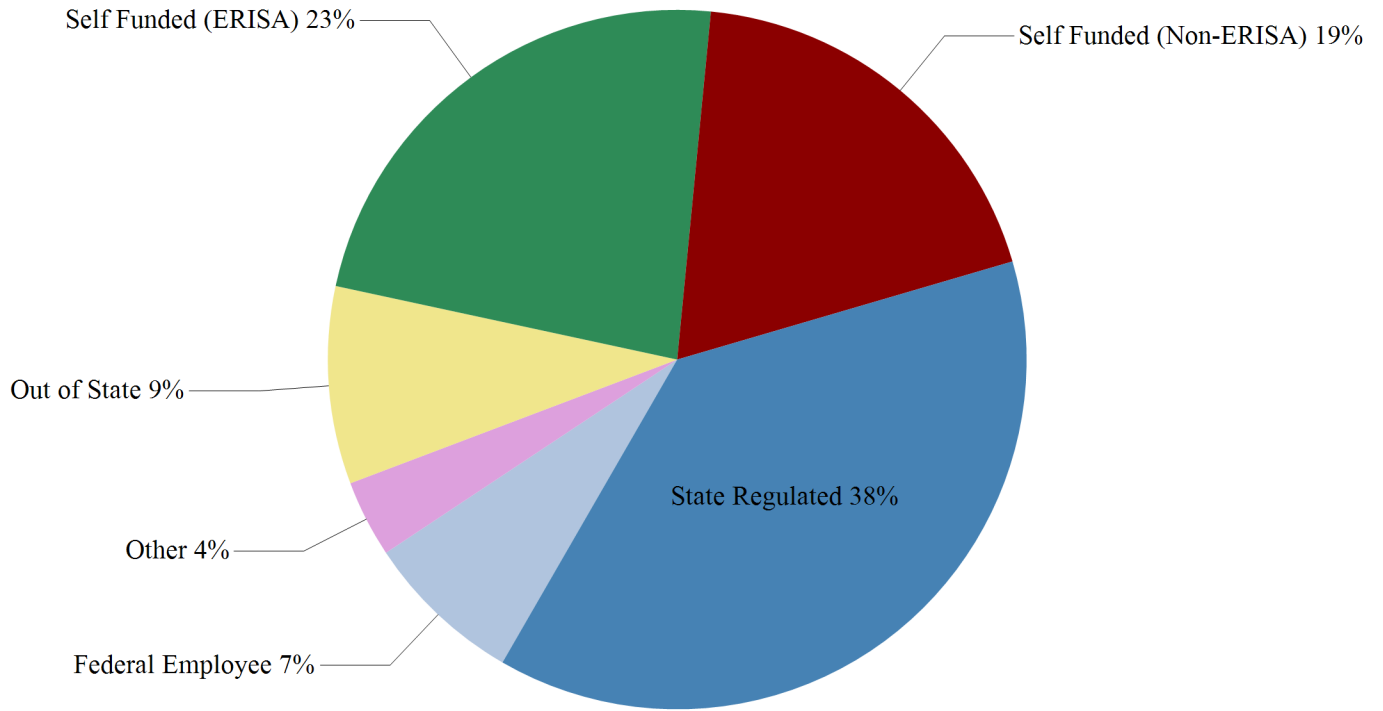
HEAU Mediated Appeals and Grievances Cases Disposition

Carriers may uphold, overturn, or modify their decisions during the appeals and grievances process. The chart below identifies the outcomes of the Appeals and Grievances cases that the HEAU mediated and closed during FY 2025.



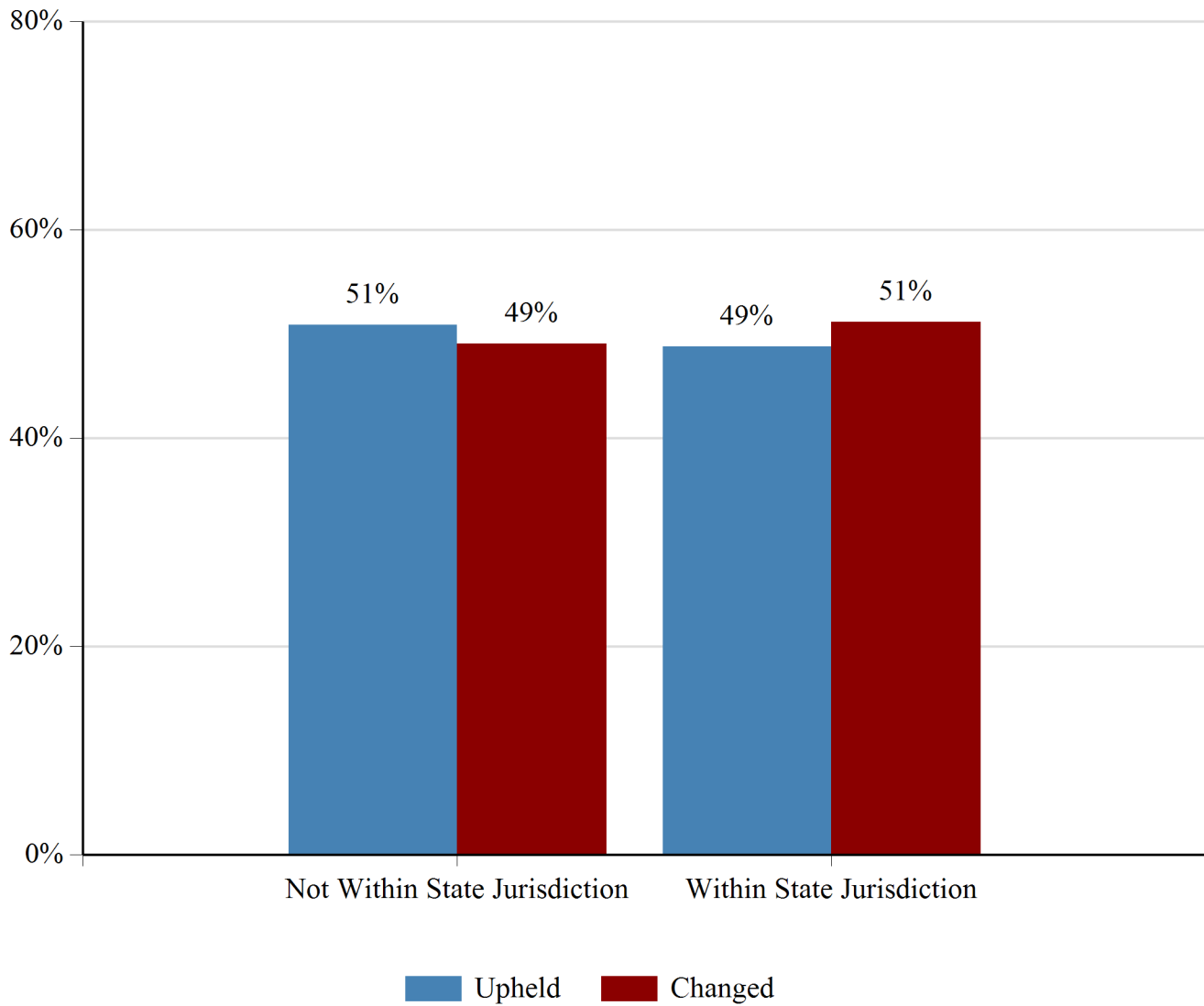
HEAU Mediated Appeals and Grievances Cases Types of Carriers

The chart below identifies the primary carrier types involved in the 449 Appeals and Grievances cases the HEAU mediated and closed during FY 2025.



HEAU Mediated Appeals and Grievances Cases Outcomes Based on MIA Regulatory Authority

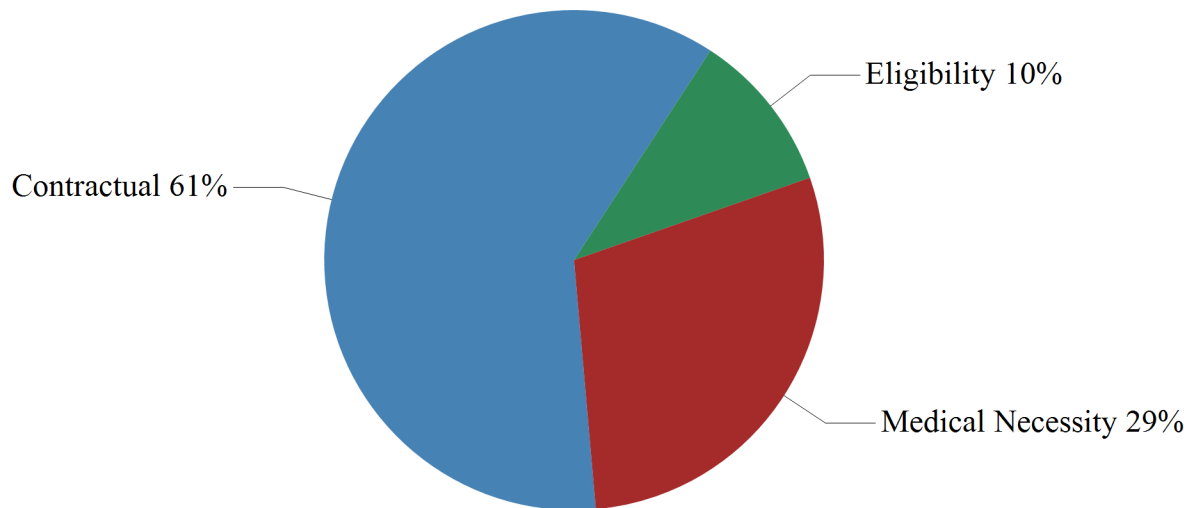
The chart below reflects the outcomes of the 449 Appeals and Grievances cases the HEAU mediated and closed during FY 2025 in relation to the MIA's regulatory authority over the primary carrier. Carriers "Not Within State Jurisdiction" may include: Medicare, Medicaid (Medical Assistance), self-funded plans, federal employee plans, and out-of-state plans.



HEAU Mediated Appeals and Grievances Cases

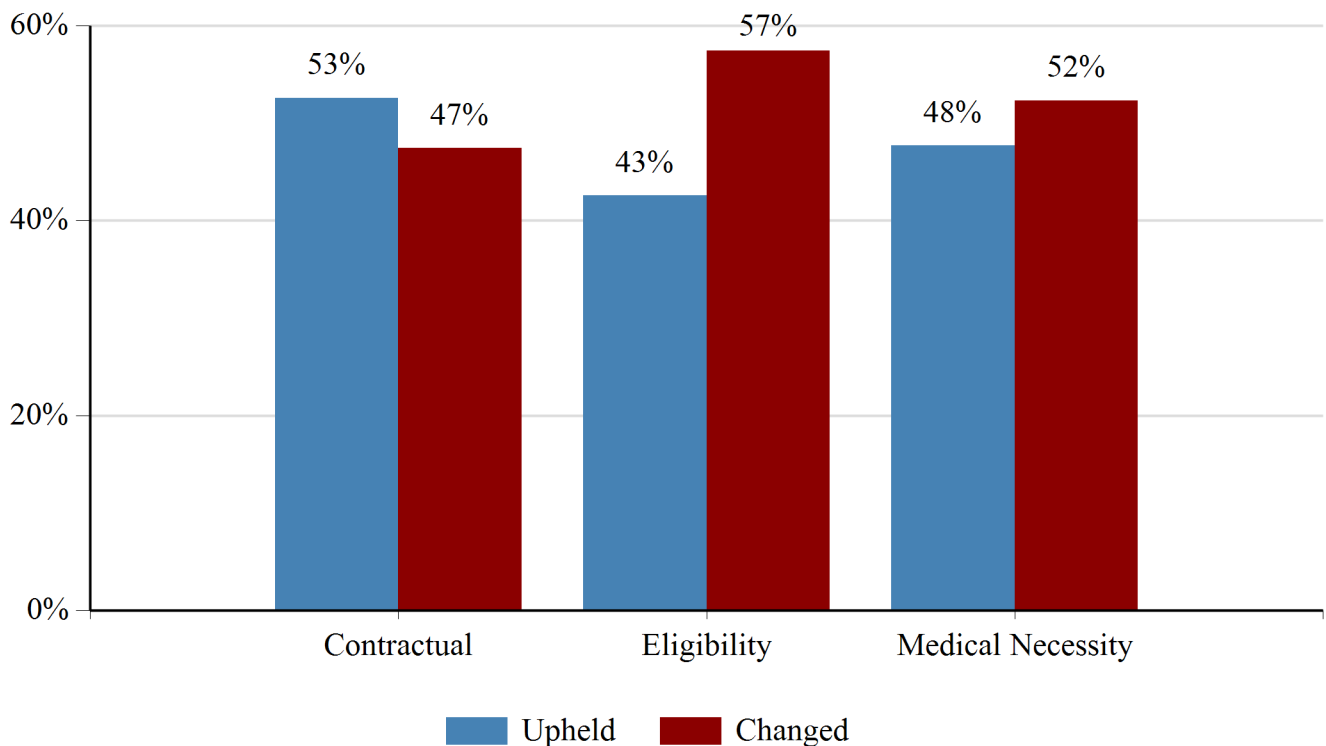
Types of Denials

The HEAU reports data on medical necessity, contractual coverage and eligibility disputes (denials, terminations and rescissions). The chart below identifies the percentages of each type of case the HEAU mediated and closed during FY 2025.



Outcomes by Denial Type

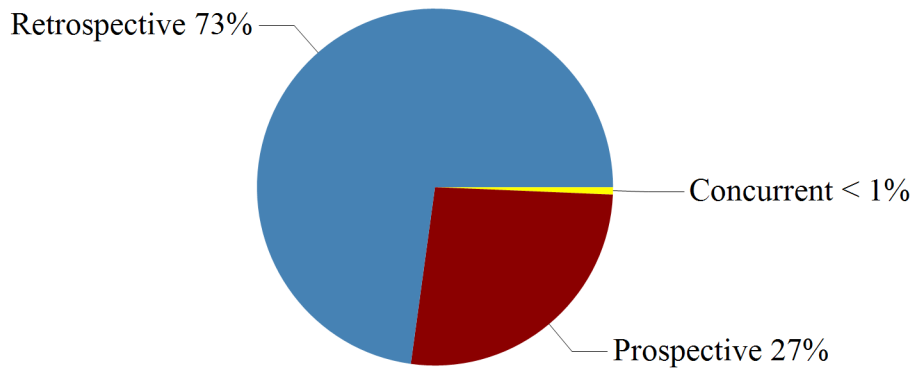
The chart below compares the outcomes of medical necessity, contractual coverage and eligibility disputes (denials, terminations and rescissions) that the HEAU mediated and closed during FY 2025.



HEAU Mediated Appeals and Grievances Cases

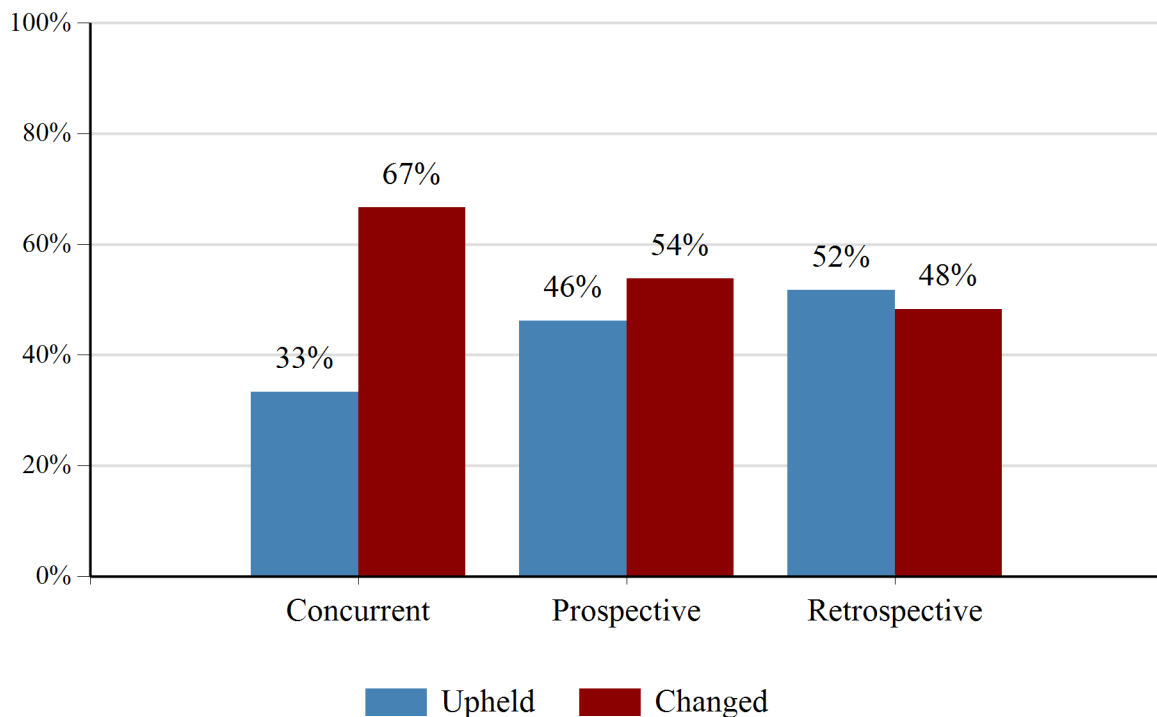
Timing of Denials

Carriers can deny coverage prior to a provider rendering a service, while a provider is rendering a service, or after a provider renders a service. The chart below identifies the timing of carrier denials for each type of Appeals and Grievances case the HEAU mediated and closed during FY 2025. Eligibility disputes are treated as prospective denials.



Outcomes by Timing of Denials

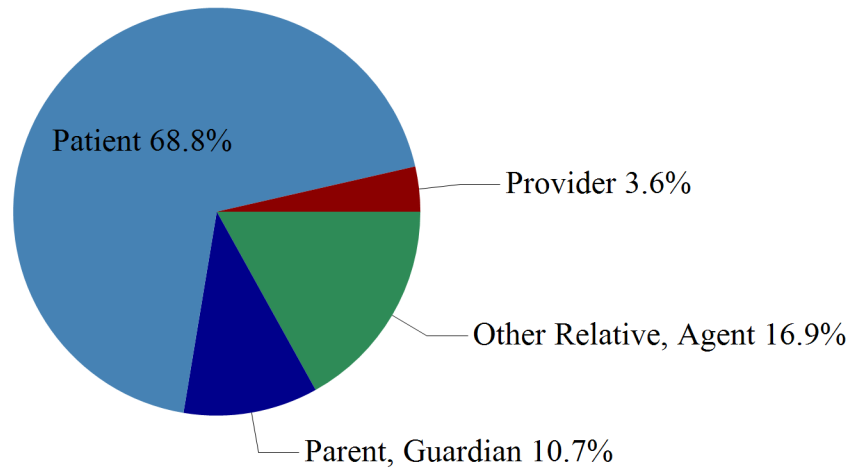
The chart below compares the outcomes of the denials that the HEAU mediated and closed during FY 2025 based on the timing of the decision.



HEAU Mediated Appeals and Grievances Cases

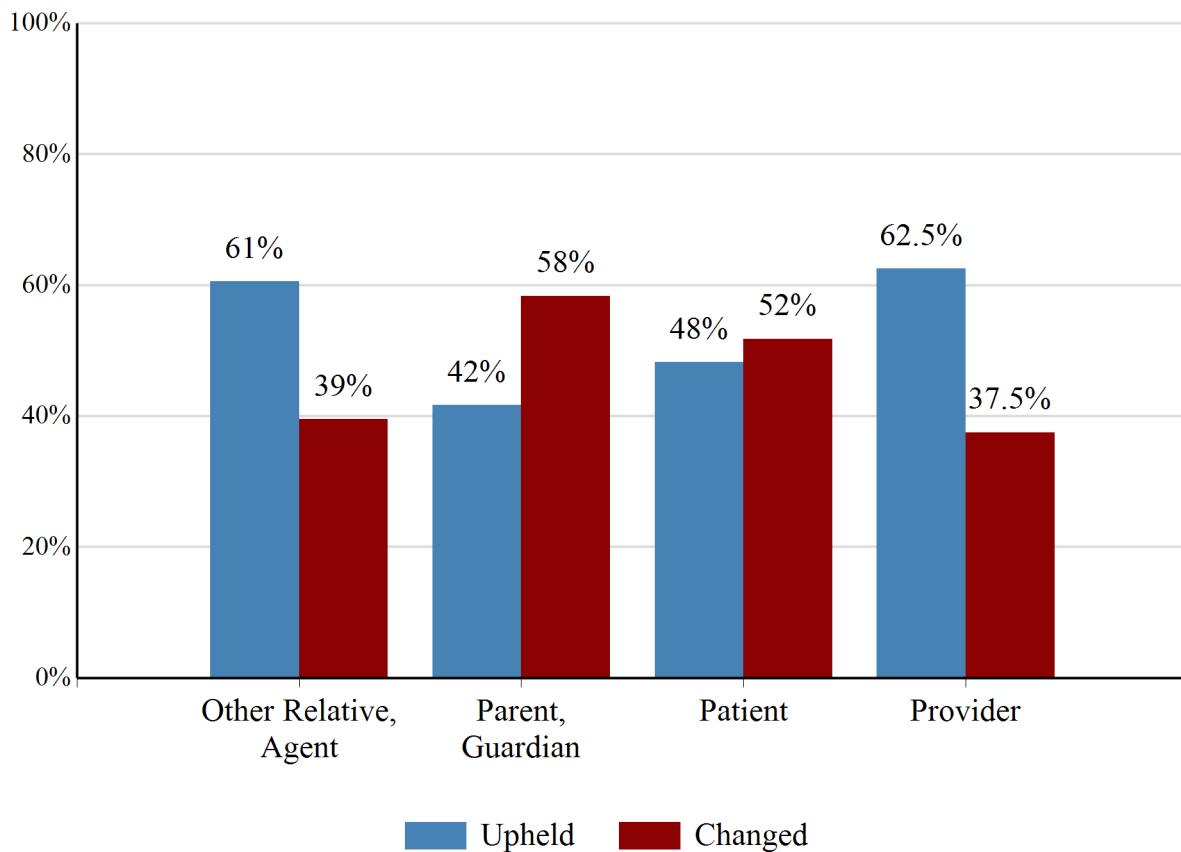
Who Filed the Case

Complaints may be filed by patients or filed on behalf of patients by providers, parents, other relatives, or other agents. The chart below shows who filed Appeals and Grievances cases the HEAU mediated and closed during FY 2025.



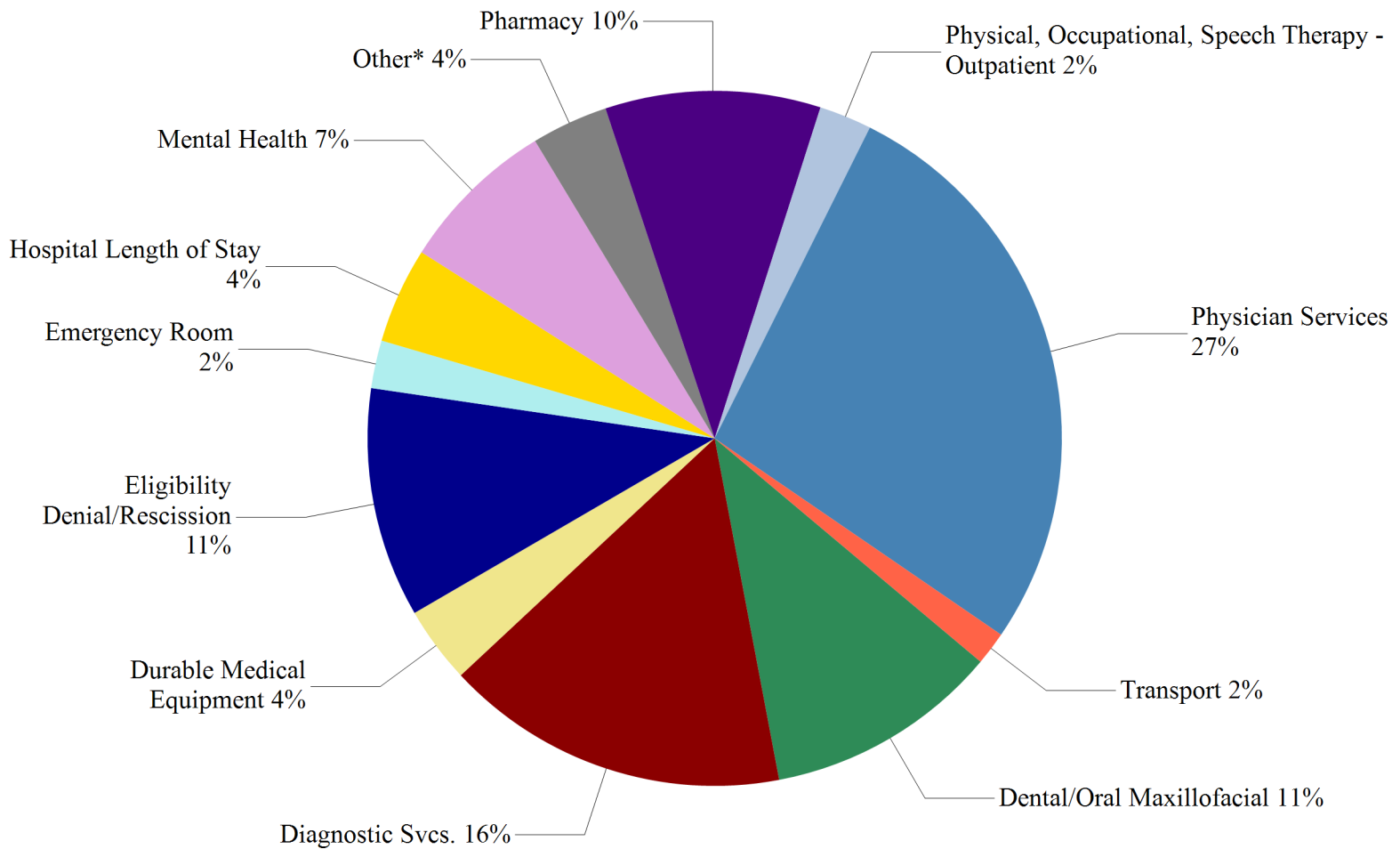
Outcomes by Who Filed the Case

The chart below reflects the outcomes, in relation to who filed the complaint, of the Appeals and Grievances cases the HEAU mediated and closed during FY 2025.



HEAU Mediated Appeals and Grievances Cases Types of Services Denied

The chart below identifies the types of services involved in the Appeals and Grievances cases the HEAU mediated and closed during FY 2025.



HEAU Mediated Appeals and Grievances Cases Outcomes by Service Type

The chart below compares the outcomes of the Appeals and Grievances cases the HEAU mediated and closed during FY 2025 based on the types of services denied.

